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INFANT SURVIVAL: A CHALLENGE FOR THE SOUTH

HEARING

BEFORE THE

SELECT COMMITTEE ON HUNGER
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

HEARING HELD IN BIRMINGHAM, AL, OCTOBER 10, 1988

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INFANT SURVIVAL: A CHALLENGE FOR THE SOUTH

MONDAY, OCTOBER 10, 1988

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON HUNGER,
Birmingham, AL.

The committee met pursuant to notice at 9:39 a.m. in the Dennison Auditorium, Jefferson County Health Department, Birmingham, AL, Hon. Michael Espy presiding.

Also present: Representatives Erdreich and Harris.

OPENING STATEMENT OF HON. MIKE ESPY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. ESPY. Good morning to everyone. My name is Mike Espy, and I am a Congressman from the Second Congressional District of Mississippi and a member of the House Select Committee on Hunger.

The first thing I would like to do today is to express to my colleagues from Alabama the fact that I will not have any regrets for the occasion of a football game. [Laughter.]

On behalf of the select committee, I would like to thank Congressmen Ben Erdreich and Claude Harris for inviting us here to discuss the persistently high infant mortality problems which plague the State of Alabama. Our visit today stems from their concerns of the factors contributing to infant mortality and the possible strategies we can advocate in the Congress to combat this problem. I look forward to continuing my work with them in the House of Representatives to implement policies and programs at the Federal level which will aid in our efforts to alleviate this problem.

I would like to note here that the number of members present at today's hearing really in no way reflects disinterest or lack of concern. As you are well aware, elections are almost upon us, we have about 30 days left before we will hopefully all be re-elected. The Congress is attempting to adjourn and the various members—the other members on the select committee—are in their districts attending previously scheduled functions.

According to final 1986 figures released by the National Center for Health Statistics, Alabama's infant mortality rate for all races was 13.3 deaths per thousand live births. A 1986 report issued by the Children's Defense Fund found that the State faces quite a few challenges if it is to succeed in meeting a number of the Surgeon General's 1990 health goals. Specifically, Alabama will have to improve its rate of progress six-fold for all races and seventeen-fold

for nonwhites to meet the low-birth-weight goal of less than 9 percent. If the State maintains its current rate of progress, it will meet the goal for infant mortality. However, it will have to improve the progress by approximately 1½ times to meet the goal for nonwhites. With respect to the goal that no less than 90 percent of all women access prenatal care during the first trimester of pregnancy, the State will have to improve its rate of progress seven-fold for all races and seven and one-half fold for nonwhites. Finally, the State will have to double its rate of progress to meet the post-neonatal goal.

Last fall, the Select Committee on Hunger conducted a hearing in Washington to examine the role of Federal food assistance programs in strategies to reduce the national infant mortality rate. That hearing was held in Baltimore, MD. During those proceedings, we were able to focus on a number of preventable causes of infant mortality, including the failure of pregnant women to acquire health care early in pregnancy and to consume an inadequate diet throughout this period. Surely there are interventions within our grasp which will enable States like Alabama and my own State of Mississippi to put a halt to the tragedy that claims so many children before they celebrate their first birthday.

In July 1987, the Select Committee on Hunger visited my own congressional district to assess the infant mortality rate and the effectiveness of Federal assistance programs. As in Alabama, much remains to be done in Mississippi before we achieve an acceptable infant mortality rate. However, I am pleased to note that we have implemented a number of innovative projects and are making substantial progress.

We are privileged today to have a number of experts who are familiar with the intricacies of the infant mortality situation in Alabama. They will share their expertise and advice for enhancing programs which offer opportunities for prevention. We will also hear from a private citizen who has experienced this tragedy in her own family and who can relate to us, on a personal level, how we can make interventions more accessible.

Before closing, I really do want to thank all of you for joining us this morning. Your attendance at this hearing indicates your interest in this problem. My district, the Second Congressional District of Mississippi, is the poorest congressional district in what remains the poorest State in the United States. With regard to the high incidence of infant mortality and low-birth-weight babies, out of every thousand live births in Mississippi, 14.2 of the children will not live to blow out the candles on their first birthday cake. And that is a tragedy, but it is one that we can prevent and that is why we are here. I am glad to be with you this morning, glad to be sitting here between my two distinguished colleagues from Alabama, Congressman Ben Erdreich and Congressman Claude Harris. In Washington, we call him the "Judge."

I would like to turn now to Ben for any opening comments he would like to make.

OPENING STATEMENT OF HON. BEN ERDREICH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

Mr. ERDREICH. Thank you, Mike. I want to thank you and Claude Harris both for being in attendance today, and welcome everyone to these hearings.

I ask unanimous consent that I have my entire statement included in the record and I will just summarize parts of it.

Mr. ESPY. Without objection.

[The prepared statement of Mr. Erdreich appears at the conclusion of the hearing, see p. 51.]

Mr. ERDREICH. We are here today surrounded by one of the greatest medical centers in the world, the University of Alabama-Birmingham, inside our county health department which has a wide variety of services, to discuss the high human and financial cost of inadequate prenatal care and what we can do to lower our State and national infant mortality rate. It is shocking to me to learn that a child born in Japan or Finland or Hong Kong or Ireland, Australia or Canada, Singapore or any 12 other industrialized nations, has a better chance of surviving his or her first year than does a child born in the United States. Worse yet, I am sorry to say, the figures for 1987 indicate that the State of Alabama is among the five top worse States in the Nation with an infant death rate that is higher than our national average.

America currently spends over $2 billion a year on health care for low-birth-weight babies during the first year of life and the lifetime cost of caring for low-birth-weight infants can reach some $400,000 per child. That cost, by the way, does not include the ongoing cost that must be shouldered by every community due to unemployment, under-employment, and the long-term care of permanently disabled.

We in Alabama, I believe, are making strides, our State and legislature and Governor Hunt, but this is a priority that must be attended to. If ever there was an area I think that preventive steps should be taken, it is here where it is estimated that you can save some $3 for every $1 spent on preventive steps. Certainly Ben Franklin's adage "an ounce of prevention is worth a pound of cure" should certainly be followed.

As I said, we are sitting right here, Mike, in the midst of a world class medical center. We have got the State's most sophisticated and accessible health care services. This county health department is unique in our State. It has seven health centers providing information and referral services. We are across the street from the Cooper Green Hospital Indigent Care facility of our county, supported by local tax dollars, but surprisingly to me, in the midst of all these services and health care resources, Jefferson County's infant mortality rate is higher than the State average, and, as we know, the State average is one of the worst in the United States.

This is partly why Claude Harris and I asked you and the committee to come here today, to look first-hand at what can be done and to hear from our panel of experts to give us some guidance on how we can better make our resources do the job that we all want to see done.

I am hopeful that this hearing will make meaningful headway in developing new strategies to ensure that our Nation's youngest and most vulnerable citizens get off to a healthy start.

Thank you, Mr. Chairman.

Mr. ESPY. Thank you, Ben. Thank you for an excellent statement. It will be included in the record in its entirety.

We turn now to my other friend and colleague from here in Alabama, Claude Harris. He and I serve on the House Committee on Agriculture, in fact we sit next to one another. I appreciate his giving me all the peanuts during the late hours that we are deliberating on agricultural policy until 2 and 3 o'clock sometimes in the morning. Claude will pass me every now and then a package of Alabama peanuts and we have been competing on catfish for awhile.

I thank Claude for being here and we will now turn to him for any statement he may wish to make.

OPENING STATEMENT OF HON. CLAUDE HARRIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

Mr. HARRIS. Thank you, Mr. Chairman. I would ask unanimous consent that my entire statement be made part of the record and I will summarize in the interest of time.

Mr. ESPY. Without objection.

[The prepared statement of Mr. Harris appears at the conclusion of the hearing, see p. 57.]

Mr. HARRIS. You know, today presents us a unique opportunity for this State and this county, because for the very first time this committee, the Select Committee on Hunger from the U.S. House of Representatives, has traveled to examine a very difficult public policy, and that being the rate of infant mortality in Alabama.

In 1986, we had the unfortunate experience of being named the State with the highest rate of infant mortality, 13.3 deaths per 1,000 live births. We strive to be No. 1 in so many areas, but this is one that is certainly a shame to the whole State.

In 1987, the rate declined only slightly to 12.2 deaths per 1,000 live births. It is my hope that after this hearing more people will understand the importance of these statistics.

You know, the tragedy of this situation is that adequate preventive efforts could greatly reduce this unnecessary loss of life. In August of 1988, a report published by the National Commission to Prevent Infant Mortality set out two goals, the first being the provision for providing of universal access to prenatal care. And second, to initiate educational efforts to make the well-being of mothers and their children a national priority for all Americans.

I believe the first goal can be realized by both expanding the health care infrastructure as well as guaranteeing coverages for services rendered in such facilities. Devising strategies to meet the second goal is more difficult to agree on. I am certain that part of the educational effort should be devoted to nutrition. We are fortunate today to have the expertise of members of the Select Committee on Hunger, who are very familiar with the nutrition needs of our children and their families. Another suggestion is to expand

the infant formula rebate system because today we have 25 States in this country that implemented this type of rebate program.

I am hopeful that the witnesses today will offer valuable suggestions to increase awareness of the issues.

Finally, Mr. Chairman, I would like to take this opportunity to thank you for coming and Ben, thank you for asking me to share in this hearing with you. And I look forward to the testimony of the witnesses as we work together on a very serious problem in our State and our Nation.

Mr. ESPY. Thank you, Claude. It is a serious problem and we are going to try to do all we can today to expose the problem for what it is and talk about ways that we can solve it. So let us get started. We have a number of excellent witnesses today.

The first is the Honorable George Perdue. Representative Perdue is already here, he is eager and is already seated. Representative Perdue is a member of the Alabama State Legislature, his district happens to include the city of Birmingham. Recently he offered legislation which assisted in the expansion of the State Medicaid system. He currently serves on the Governor's Task Force on Infant Mortality, the Southern Governors' Association Task Force on Infant Mortality, and the Alabama Perinatal Organization.

We are honored to have you here this morning and we would like to ask you to proceed.

STATEMENT OF GEORGE PERDUE, STATE REPRESENTATIVE, ALABAMA LEGISLATURE, CITY OF BIRMINGHAM

Mr. PERDUE. Thank you very much, Mr. Chairman, my Congressman, Congressman Erdreich, Congressman Harris, and other distinguished guests.

I appreciate the opportunity afforded me today to share with you some of my concerns about infant mortality in the State of Alabama. My concerns are both personal and legislative.

I am the parent of a low-birth-weight—2 pound, 2 ounce—baby born in this State in 1976 in Jefferson County. She was hospitalized for the first 67 days of her life. Fortunately, due to the very fine, excellent level of care she received in the facilities in Jefferson County, she was not a statistic. She experienced no long-term nor short-term defects, she is normal in every way, a straight A student in sixth grade and slightly overweight.

Legislatively, I became involved with efforts to combat the State's high infant mortality rate in December of 1984, approximately 1 year after I became a member of the Alabama Legislature. I was appointed to the Southern Governors' Association Task Force on Infant Mortality. This task force was comprised of southern Governors and first ladies, State legislators, mayors, public health experts, and national civic leaders who were concerned about the health of our next generation of children.

During that year, of the 58,604 Alabamians born, 815 died before their very first birthday. The cold statistics work out to be almost 14 deaths per 1,000 births, one of the worst in the country at that time.

In my work over the past 4 years with the Southern Governors' Association Task Force on Infant Mortality, and more recently

with the Advisory Committee of the Southern Regional Task Force, as well as my work on the Governor's Task Force on Infant Mortality, a number of points stand out in my mind as to why our babies are dying.

(1) A child's chance for life depends on the prenatal care the mother gets. A child's chance for health depends on the mother's nutrition. By that measure, many of Alabama's children are penalized before they are born.

(2) Nearly one-third of all Alabama women who had babies in 1985—more than 18,000—depended on the county health department clinics for all the prenatal care they received. By some estimates, more than 1,000 others had no prenatal care—the most risky pregnancy of all. In 21 of 67 counties in the State, that care is not available.

(3) One of every three obstetricians lives in Jefferson County, while 30 counties do not have a single resident obstetrician, even for the women who can afford private care.

(4) Many of those newborns and their mothers are not well fed either. The nutrition programs are among the most minimally funded in the Nation. Thousands of malnourished women are having malnourished children.

That begins to explain why Alabama still has one of the highest infant mortality rates in the United States, which means it is one of the worst in the industrialized world.

(5) The question of prenatal care and deliveries for poor women is a loaded one, because a whole set of issues comes with it—family planning, sex education, welfare, malpractice and finally, the unpaid bill.

(6) Who should pay for deliveries if the woman or the family cannot pay for them; the county, the State? Who pays the bill for unplanned births when contraceptives are available at health departments? Do welfare payments encourage health or discourage responsibility?

The questions are not new, but some doctors have begun to find a fresh answer. They are simply withdrawing their services. Some no longer accept Medicaid patients at their own offices, some are fearful of malpractice suits, some are unwilling to perform deliveries for poor women, while others say the county clinics only give women an excuse to avoid arranging private care.

(7) So the clinics are closing, leaving maternal care worse than it has been in a decade. Some of those counties are serviced by nurses or nurse practitioners, but thousands of pregnant women will have to drive further down the highway.

Legislatively, what does all this mean? First of all, it is very clear to me that though the health department may have been doing all it could, it certainly has not, in the past, had much money with which to work. Support for prenatal care and family planning programs has been mostly from Federal funds, and they have been impacted by Gramm-Rudman budget cuts. Aid to Families with Dependent Children payments from Federal block grants in 1985 were a minimal $118 per month. That is 16 percent of the Federal poverty level for a family of three—lower than any other southern State. The Women, Infants and Children Program, WIC, a Federal program which provides nutrition food supplements for the poor aver-

aged only $7.14 per week in 1985 and $7.42 per week in 1986 for each of the State's 70,000 clients.

So what has State government been doing all the while these gloomy facts have been written about in many newspapers across the State, most notably in a "media blitz" over the past 2 or 3 years?

Prior to 1986, not much. Although Congressman Sonny Callahan, as a member of the Alabama Senate in 1980 sponsored and passed legislation to establish the Alabama Perinatal Act, no funds were appropriated. Senators Charles Martin and Hinton Mitchem amended the act in 1981. It was not until November of 1986 that the legislature allocated $2 million for infant mortality—$100,000 for family planning, $1.9 million for prenatal care. Only a small share of that initially was spent for prenatal services. Most of it paid for high-risk pregnancies and intensive care for premature babies and other newborns.

The State, in other words, was treating the symptoms of poor maternal health, not the cause, and the legislature showed little interest in expanding, or even propping up, prenatal care.

In 1986-87 legislative session, budget requests were made to increase prenatal funding from $2 to $4 million for the ensuing year. However, this amount was level funded during that fiscal year.

During the 1987-88 session, a push was made by several legislators to appropriate $5 million to implement a Federal program known as SOBRA, which stands for Sixth Omnibus Budget Reconciliation Act. The program allows expansion of Medicaid services to more pregnant women and infants, with State funds, drawing almost three times their total Federal dollars.

The $5 million appropriated by the House version of the 1987-88 general fund budget was rejected by the newly appointed Medicaid commissioner. The commissioner indicated that he needed no new funds for the agency. In fact, he had cut the Medicaid budget by 5 percent to comply with the newly elected Governor's directive to trim back all State agency budgets by 5 percent due to shortfalls projected for the 1987-88 general fund budget. Much confusion developed. The perinatal funds and Medicaid expansion as well were in jeopardy.

First, the Senate Finance and Taxation Committee's substitute budget deleted all of the perinatal appropriation, all $2 million. This bill transferred $1 million to Medicaid to be used for Federal match and the other million went to higher education. Senator John Rice amended the substitute to restore at least $1 million to the perinatal program. A flurry of activity took place by advocacy groups. Many contacts were made with the Senate and House members including discussions by yours truly with the Senate Finance and Taxation Committee chairman, the House Ways and Means Committee chairman, and the legislative fiscal officer. Perinatal and Medicaid expansion needs were refocused. In summary, perinatal got back the $2 million; $1 million was allocated for Medicaid expansion and both houses of the legislature expressed legislative intent on how the Medicaid funds were to be spent for the SOBRA Program. The Senate joint resolution further stipulated that implementation would be done of the SOBRA Program by January 1, 1988.

A battle ensued among the Governor, Medicaid director and several legislators regarding the implementation date as well as methods used to fund the SOBRA Program. The Medicaid commissioner favored raising the State matching funds through local effort. The legislature favored a State general fund appropriation. The Governor vetoed the Senate joint resolution, prompting Senator Bennett to request an attorney general's opinion on the matter. The attorney general's opinion sided with the legislature, indicating essentially that legislative intent was duly expressed by both houses and that it had the force of law, Governor's veto notwithstanding. A lawsuit was subsequently filed by the attorney general and three legislators, Senators Bennett, Horn, and Representative Perdue.

This lawsuit was subsequently withdrawn, allegedly because the Governor would not sign off on moneys needed to hire expert witnesses which the attorney general had requested in preparation for trial.

On July 1, 1988, finally the SOBRA Program was implemented using a limited amount of appropriated funds and some private funds on a selective basis for several designated counties within the State. Testimony at this hearing by the Medicaid commissioner details the exact level of implementation contained in the program from July 1 through September 30, 1988. The State's new fiscal year began October 1, 1988.

The current status of the expanded Medicaid eligibility is as such. As a member of the Alabama Legislature, I first of all feel very deeply involved in this program, such that we need to know the climate under which the SOBRA legislation took place.

With time running out on the Alabama Legislature to approve a general fund budget for the ensuing fiscal year, less than an hour before the budget was to take effect, the legislature gave its final approval to a budget which appropriated $6,049,592 to expand Medicaid eligibility to include approximately 20,000 more women and infants throughout this State. This amount coupled with the matching Federal funds allocates roughly $22 million for SOBRA. In addition to the above amount, $2.4 million was appropriated to the Department of Public Health for SOBRA services program. Legislative intent was written into the public health section of the budget stipulating "at least $2 million shall be spent on perinatal projects."

Legislative intent was also written into the Medicaid line item of the budget which was sponsored by yours truly, and was unanimously adopted into the budget during the regular session. The text of that amendment is as follows:

It is the intent of the legislature that of the above appropriation, which includes $22,489,144 for SOBRA, Medicaid eligibility shall be extended to include, to the fullest extent possible, pregnant women and children up to 1 year of age who have incomes at or below 100 percent of the Federal poverty level. It is the further intent of the legislature that the provisions of the State's SOBRA Program will include raising to a minimum of 80 percent of the physician's reimbursement level the reimbursement for certified midwives for deliveries under Medicaid. Also, it is the intent of the legislature that the State's SOBRA Program provides for physician reimbursement for deliveries at minimum per patient which is above the national Medicaid average adjusted annually for global delivery fee, and that such fee be reviewed periodically by the Alabama Medicaid Agency to ensure the rate structure provides access to prenatal care. In addition, the legislature intends that SOBRA provisions include reimbursement to pediatricians who attend a high-risk Medicaid covered de-

livery. The legislature intends that SOBRA provisions in the State allow pregnant women who are determined to be eligible for Medicaid through SOBRA remain eligible throughout their pregnancy, that an assets test shall not be required in making a determination of eligibility for such program, and that all providers designated under Public Law 99-509 [SOBRA] may be certifiers of presumptive eligibility for Medicaid which will ensure that eligible State population have access to said services.

The Medicaid Agency will reimburse the Department of Public Health for actual costs, in compliance with OMB Circular A-87, for services provided.

A great number of recommendations from the Governor's Task Force on Infant Mortality, on which I serve, are included in the above legislative intent.

Testimony given here today by the Medicaid commissioner and the State health officer include a number of recommendations made and published by the task force.

Where do we go from here? First of all, let us observe a few more points about what happened in the legislative session recently:

It took three legislative sessions during 1988 to pass a general fund budget—a regular session and two special sessions.

Expanding Medicaid eligibility to the extent achieved raised a number of taxes, although a number of other social services were enhanced as well.

Medicaid was funded at $114,726,351. That is up $13 million from 1987-88.

Public Health was funded at $28 million, up $3.2 million from 1987-88.

Several county health departments raised fees in order to meet their needs at the local level.

The legislature, Governor, State health officer, Medicaid commissioner, each, set expanded Medicaid eligibility as a top priority although varying and sometimes conflicting approaches were proposed during three legislative sessions.

Though a record number of substitute general fund budgets floated through both House and Senate Finance Taxation Committees as well as floor substitutes, all versions included substantial amounts for the SOBRA Program and all included identical language expressing legislative intent.

PARTNERS, an advocacy group for improving women's and children's health in Alabama, played a very vital role in bringing to the attention of the Alabama legislature and public at large the necessity to do something about Alabama's infant mortality problem. This group lobbied extensively throughout the legislative sessions from 1986 to 1988.

The news media across the State did a superb job in helping to educate the public on the devastating infant death rate in Alabama.

Tort reform legislation including the Medical Malpractice Liability Act positively impacted the environment affecting efforts to reduce infant mortality.

A comprehensive case management approach has been recognized as a key component in combating the State's high infant mortality rate.

One or two recommendations at this time:

The legislative initiatives of 1988 are only just a beginning. More funding will be needed to achieve a minimum acceptable level of maternal and child health care in this State.

Maternal and child health care must be a priority in State government.

The perinatal program, the only program currently reaching persons who are at or below 150 percent of the Federal poverty level needs expanded funding. The Children's Defense Fund, for example, recommends eligibility at 185 percent of the Federal poverty level.

Finally, our basic problem in maternal and child health care in the country as a whole is that our health system is administered by so many agencies; it is so fragmented that there is no system left.

Instead of Congress putting a little bit here, a little bit there, Congress needs to restructure so that every citizen has access to a minimum level of health care.

This, ladies and gentlemen, is my testimony before this House Select Committee on Hunger. I appreciate your time and indulgence.

[The prepared statement of Mr. Perdue appears at the conclusion of the hearing, see p. 59.]

Mr. ESPY. Thank you Representative Perdue for appearing and we thank you for your excellent statement. It is very clear from your personal situation with your daughter. You compliment her on her perhaps being overweight and also the fact that she has maintained straight A's since she has been in school.

Mr. PERDUE. Thank you.

Mr. ESPY. Also thank you for your thorough testimony. It is pretty clear that you have been an advocate of this issue throughout your tenure with the legislature and that you are a champion of this cause in the Alabama Legislature.

Let me ask you just one question because we want to move on to the other witnesses and we want some time for our colleagues to question you as well. Your testimony indicates that there are about 30 counties without a single resident obstetrician.

Mr. PERDUE. That is correct.

Mr. ESPY. Even for women who can afford private care. I would like to ask you what steps are being taken in Alabama to encourage the migration of doctors into this underserved area and to what extent is Alabama relying on the National Health Service Corps Program for the placement of specialized physicians in underserved areas of the State.

Mr. PERDUE. Well first of all, I do believe that the environment that existed prior to the passage of tort reform and the Medical Malpractices Liability Act had much to do with doctors not going into the rural areas because of their extreme exposure to lawsuits. Having passed that legislation just 1 year prior to this legislative session, I believe that that will positively impact doctors being willing to come back into an area.

We also increased the reimbursement to physicians by more than 50 percent. That amount was $450 prior to 1987, it is now $675, which is about the average in the southeastern area. I believe those two measures together will encourage doctors to come back.

I don't know what the activity has been in regard to the Federal initiative of getting doctors back.

Mr. ESPY. Are you aware of any effort on the part of private industry to assist State and local governments in retaining or attracting physicians? For instance, in some counties in Mississippi, some of the banks will get together and will offer, let us say, liberal credit terms to some physicians who might want to gravitate toward rural areas and unserved areas. Is there any effort in this area to develop some sort of private/public partnership to do that?

Mr. PERDUE. Well there are some efforts. As I mentioned earlier, the Medicaid commissioner wanted to get involved in the local effort, fund raising, and making them aware of the problem. There is some private/government cooperation. I do not know the exact extent in terms of inducement, but there is some activity in that area.

Mr. ESPY. Thank you. Ben.

Mr. ERDREICH. Thank you, Mike. George, I want to thank you for just excellent testimony. If we could take that as a blueprint for action at both the State and Federal level, I think we could certainly accomplish something.

You underscored what I guess is the major thrust of the problem, or the overview, in trying to achieve universal access to prenatal care. With the dollars that the legislature did ultimately allocate under the expanded Medicaid or SOBRA Program, taking the Federal matching which brings it, I think in your testimony you said to $22 million——

Mr. PERDUE. That is correct.

Mr. ERDREICH. Plus another $2 million that went to public health activities. Have we gotten any closer though to the universal access that you view as needed?

Mr. PERDUE. No, we have not. As a matter of fact, the initiatives that we currently undertook only take care of about half, about 50 percent of those in-need persons that we are trying to target. So consequently this is only a beginning. The next year we are going to have to try to go and get that other 50 percent. We are going to need more than $6 million in order to get that 100 percent or close to 100 percent of those persons in need. So we are only half way.

Mr. ERDREICH. The program is one program—and you also touched on, which I agree with you, the multiplicity of programs, there are some here and some there, a variety of programs—however, do you believe that if this single program were expanded and extended, would it come close to achieving the access to prenatal care that I think we all believe needs to be done?

Mr. PERDUE. Well, I hate to be pessimistic about it. I think that with the great strain that we have on State dollars with tax reform coming up in the next year, with education reform—meaning we are going to restructure our moneys—we are going to have a tremendous battle, tremendous fight, even more so than the one we had this past session, which as I said before, took some tax moneys and tax revenues to get to this point.

We are going to have to continue to highlight those persons in need and identify how many we are talking about in order to be able to attack this problem. I cannot answer you 100 percent except that the fight has just begun.

Mr. ERDREICH. Thank you.

Thank you, Mr. Chairman.

Mr. ESPY. Thank you. Claude.

Mr. HARRIS. George, one thing you mentioned is the fact that you feel like maybe there are too many agencies. Do you have any further thoughts that you can share with us on that as to how we could best restructure the system so we could get the most for our dollar?

Mr. PERDUE. Well I am not an expert on the programs that are available throughout the Federal Government except that I know there are a number that need to be coordinated to reach that segment of people. I think if we had national health care at the Federal level, I think that would pretty much solve the problem. We are a long way from getting to that point, I understand that.

Mr. ESPY. Sounds like a presidential candidate.

Mr. HARRIS. You know, in reading a report that was in the Montgomery Advertiser—a very well done report, I might add—I notice that one of the statistics was that for every dollar that we spend on prenatal care, that we can save $3.38.

Mr. PERDUE. That is correct.

Mr. HARRIS. That should be a compelling figure, it appears to me, to people that we can—where there is that kind of savings, that we should be doing that, put more into the program on the front end and save on the other end.

Mr. PERDUE. That is one of the arguments we have been using both in the legislature and all of our groups across the State, we have been trying to get the attention of the legislature, that we are actually saving money. We are not allocating more money, we are saving money on the other end—that we should be taking advantage of that. So I think it was a very effective job, however, it was only the beginning.

I might add that the way we were able to do that had to do with a political situation involving the executive branch and the legislative branch as to whose initiative was actually going to prevail in this area. Varying amounts were mentioned for appropriation. We were in a very good position to bargain with both executive and legislative branches to come out with the best program at this time.

I am not unaware that we were just in a very unique situation, that we were being kicked around as a political football for awhile, everybody had to make some initiative for infant mortality, and we were fortunate to be in that position.

Mr. HARRIS. Well, I commend you for your efforts.

Thank you, Mr. Chairman.

Mr. ESPY. Thank you, Claude.

We thank you, Representative Perdue, for being here and we will include the entirety of the statement in the record.

Mr. PERDUE. Thank you.

Mr. ESPY. We would like now to call the next panel of witnesses; Dr. Earl Fox, Mr. Mike Horsley, Dr. Mary Ann Pass and Dr. Christiane Hale. Please come forward and assume a place at the witness table.

While you are coming forward, I will just go ahead and start my introductions. Dr. Fox is the State health officer. Prior to his ap-

pointment here in Alabama, he served as deputy health officer in my home State of Mississippi, where his work was critical in helping to reduce the rate of infant mortality. Also prior to relocating here in Alabama, Dr. Fox was president-elect of the National Association of Maternal and Child Health and Crippled Children's Association.

I would like to also add that in 1984, the American Public Health Association, Maternal and Child Health Section, gave Dr. Fox the Outstanding Young Professional of the Year Award.

Mr. Horsley was appointed in 1987 by Governor Hunt to the post of commissioner of the Alabama Medicaid Agency. The commissioner also chairs the Governor's Task Force on Infant Mortality and is a member of the State Health Coordinating Council and the Governor's Health Advisory Committee.

Dr. Pass is the deputy health officer for Jefferson County. Her primary fields of expertise are pediatrics and public health. She oversees the delivery of clinical services for the county and chairs the Jefferson County Perinatal Advisory Committee.

And Dr. Hale is a professor at the School of Public Health and is director of the Maternal and Child Health Training Program. She has received international recognition for her work in epidemiology and I would like to note her latest series of publications addresses infant mortality in Alabama.

I would like thank all of you for appearing at the hearing this morning and would ask you, if you could, to summarize your testimony.

And let us start by going to Dr. Fox first. You may begin.

STATEMENT OF CLAUDE EARL FOX, M.D., STATE HEALTH OFFICER, ALABAMA DEPARTMENT OF HEALTH

Dr. Fox. Thank you, Mr. Chairman. You all have a copy of my written comments and I would just like to make some statements. I am not going to go through and read that.

Mr. Espy. Without objection, your entire testimony will be included in the record.

Dr. Fox. Thank you. I also want to give you my thanks for each one of the members on this panel because I know that each of you has a personal interest in infant mortality, and I know that has gone far beyond your attendance at this meeting. We have had a number of contacts with each of you in the past and we really appreciate that.

I have had a long interest in maternal and child health. I did work in the Mississippi Delta and had the opportunity to see many of the problems there that are prevalent throughout the South.

I am a pediatrician by training. I came up through the public health system. I worked as a local health officer in Tallahatchie County and several other counties and then later as a district health officer and then at the State level, and have been here for the last 2 years.

As those of you know, we have a number of contributing factors in infant mortality. There is certainly no easy solution, just like there is no one single cause. I would like to relate just quickly a

few of the factors that I believe contribute to our problem with infant mortality.

The first is the issue of race. We know that in Alabama as well as most of the other Southern States, our black population has a greatly increased risk of death. In fact, the black rate in Alabama is more than two times the rate of death for white infants. Some of the reasons are clear, some are not. But this is a major problem.

Another is age. We know we have a problem with teen-age pregnancy in Alabama, that over 17 percent of our births are to teenagers, and that over 18 percent of those are repeats. So we are not doing a very good job the first or second time. We have an increasing number of births to children under age 15. In fact, we had a 27-percent increase last year in Alabama. This is a huge problem.

Educational level. And we know this is of course a proxy for income and many people that have a limited educational level have an inability to pay for their services and thus may not receive them. Educational level—one-fourth of all of our births in Alabama are to women with less than a high school education.

Other factors relate specifically to the health care system. We know that we have I think a minimally functional regionalized perinatal system in Alabama. We have a lot of fragmentation, a myriad of agencies deal with care, and even the agencies that are represented in this room, and others, have different eligibility standards, different things that we require for people to get through our doors to provide service. And that in many instances provides a barrier.

We have different locations. We know that many of the components that we consider adequate for a perinatal system are not there in all the counties in Alabama, such as the ability for people to receive care regardless of income, high-risk in-patient care for mothers and newborns, transportation of both the mother and the infant when they are ill, OB services, education for hospital personnel, high-risk follow up for those small babies that are born that need follow up after birth. Those things are not present in many cases.

We have a maldistribution of providers. As most of you know, the family practitioner has almost gone by the wayside as far as OB care is concerned, and many of our obstetricians are leaving practice. We have problems getting providers in health departments as well as in the private medical community.

Forty-two of our counties in Alabama, out of 67 counties, have nurse-only prenatal clinics in the health department. They do not even have a physician there to provide backup. This is certainly a major problem. Twenty-eight of our counties have no OB delivery services, within those counties.

We know that we have a difficult time finding high-risk referrals of mothers and infants across the State. We do not have any uniform system for follow up for high-risk infants.

Malpractice has caused a reluctance for many physicians in this State even who are doing OB, to take high-risk patients. Even obstetricians who are trained to do high-risk care may in many instances be hesitant to take high-risk patients because of the malpractice liability.

Also we know that we have a problem with getting access to care for sick infants and sick children across the State, and that is a major contributor to mortality even after the infant and mother leave the hospital.

What have been some of this State's strategies to reduce infant mortality already? We had a Senate democratic forum in July of 1987 and immediately, 2 days after that forum, the State Legislature passed an act to help provide dollars for the SOBRA expansion. We have had two special legislative subcommittees looking at infant mortality.

I developed and chaired an infant mortality task force prior to the Governor appointing his, and we now have a Governor's task force in this area. Later we had a Governor's Conference on Infant Mortality that was held in January of 1988 with over 200 of our leading business people in attendance.

As Representative Perdue has already mentioned, 1987 was the first year that we had State dollars for maternal and child health. We have now a mandatory sickle cell screening that we are quite proud of, where we screen 100 percent of all our infants at birth.

In the health department, we have mandated that all county health departments provide what we call core health services in all 67 counties every day of the work week, and this includes prenatal care and pediatric services. We have increased our screening of Medicaid-eligible children from 16 percent a couple of years ago to over 40 percent statewide now. And this just means that we have a large number of Medicaid children getting health services through the county health departments.

We are adding social workers throughout the State to provide follow up and we have initiated infant death reviews, where we actually take our birth and death certificates and look at them to try to see what went wrong with the system.

We have implemented at the State level a 1-800 number called "Storkline" that received a national award recently. .We have received over 1,100 phone calls. This is a phone line that mothers and infants use in order to access prenatal care. If they have trouble getting care, they call in and we have a resource manual where we can tell them where they can find care out in their local area.

We have received a number of Federal grants in the last year. We have a maternal and child health grant for central Alabama, an Office of Adolescent Pregnancy Prevention grant, a grant from ARC, Robert Wood Johnson Foundation, March of Dimes, and Children's Trust Fund. All of these are to provide services.

There has been a grassroots advocacy effort, as Mr. Perdue alluded to. I think this has been a key in Alabama getting where we are now. We are certainly not where we need to be, but this has been I think an absolutely essential effort.

We know that WIC—its role in reducing infant mortality has been notable. And I might say that having worked in a health department starting in 1974, when we did not have WIC in Mississippi, and none of the other States had it either. This was prior to nationwide implementation. And I saw infant after infant come in with what we call failure to thrive, very small infants who were not gaining weight because they did not have formula, did not have adequate nutrition. We almost never see that now in the health de-

partment. I think WIC has had a major impact in helping to reduce our low birth weight and helping to reduce our infant mortality.

There have been a number of studies, a 1986 national study, that verified some of this. We know that WIC is a major carrot for getting people into health care. Many of our patients that come in would not come for prenatal care, would not come in for pediatric services, but they will come in to get WIC. So it is an entree into the system, it is a draw and it really helps to bring them into the health care system. We are serving over 43,000 mothers and children in WIC in Alabama.

You all may know that recently we bid out the WIC infant formula in three areas. We have not impeded the access to formula, but we were spending several million dollars in this State. We are saving $10 million a year on WIC formula now with our bid. We have a 36-month contract and will save over $30 million. That money will all be plowed back into WIC. We are going to be able to add at least 17,000 additional patients per month on WIC with this money. We are very proud of that and very pleased with what we have been able to do.

We feel like there are a number of other strategies that need to be done in this State. We will be working to help support those. Just in closing let me mention some of the things that we feel are yet to be done and need to be done.

I want to say that certainly within the area of Medicaid, we do support increased Medicaid expansion. At some point we need to go to 185 percent of poverty, we are at 100 percent of poverty now, and we feel the Federal option to go to 185 percent certainly would be beneficial to Alabama. We need to still go up on our OB and pediatric fees under Medicaid. I contend it does not do anybody any good to have a Medicaid card if a physician will not see them and they cannot get into care. So we need to do that.

I think there needs to be a look at standardizing Medicaid eligibility at the Federal level. That would certainly be helpful to all of us. We need statewide case management. We need people that are out there to help shepherd patients into the health care system. Most of us in this room could not get into the health care system if we had to do it ourselves, we place so many barriers for eligibility. Particularly low-income people have a difficult time. We need some way of doing this through Medicaid and through non-Medicaid programs to help people get in and get in early.

We need to increase our State support, certainly we have inadequate support for the health department. I would say, however, that we do not need to put moneys that are already being used in Medicaid or in prenatal care in other agencies into Medicaid, pull them out of one agency and put them in another. That has happened in some States and I think it has been a mistake.

We need a strong system at the Federal level in title V. The Maternal and Child Health Care block grant that is a Federal program, is only now getting back to where it was in 1980 adjusted for inflation. So we need further funding for that.

We need to basically make prenatal care and infant care a right, an entitlement and we should not have any low-income mother or child in this country that goes without it.

That completes my statement. I appreciate the opportunity to testify before this committee and I will be glad to answer any questions.

Mr. ESPY. Thank you, Dr. Fox. We are going to hold questions until we complete testimony from all the panelists. I thank you though for your testimony. You have certainly presented compelling testimony.

Let us go next to Commissioner Horsley. Welcome commissioner.

[The prepared statement of Dr. Fox appears at the conclusion of the hearing, see p. 73.]

STATEMENT OF J. MICHAEL HORSLEY, COMMISSIONER, ALABAMA MEDICAID AGENCY, MONTGOMERY, AL

Mr. HORSLEY. Thank you, Mr. Chairman, Congressman Erdreich, Congressman Harris, I thank you for the opportunity to be here.

I would like to say that the problem of infant mortality was around when Governor Hunt's administration took office in January of 1987, had been for a number of years. And Alabama has had that distinction of being in the top five States in the Nation for a number of years. Upon taking office, I will have to say that that first legislative session within a couple of months after taking office was—that was not the problem as we saw it at the time. But since that time, we have become aware of the problem and Governor Hunt is showing deep concern with social issues in this administration and the problems of infant mortality and morbidity have been a high priority. Those victories were far from easy.

The Governor succeeded in the most recent legislative session in raising revenue necessary for adequate funding of health and human services for the 1989 fiscal year. The focus of the budget battle was on the need for better funding for agencies that serve people at the lowest income.

Many changes have come about in the State of Alabama over the last year to improve maternal and child health services. Dr. Fox alluded to some of these and I would like to go over some of those.

The Medicaid expansion which took place in July provides health care for thousands more mothers and children under the Sixth Omnibus Budget Reconciliation Act. Congress is to be commended for passing this legislation because it allows States, for the first time, to expand health care services through Medicaid without tying that expansion to cash assistance payments through the welfare system.

Alabama is now serving pregnant women and children up to 1 year old in families with incomes at or below the Federal poverty level. Before that change, eligibility for Medicaid reached only those mothers and children at less than 15 percent of poverty, those families that were receiving Aid to Dependent Children, which in Alabama also means that it could not be a two-parent household.

Women qualifying under the expansion receive pregnancy-related services and children qualify for all Medicaid services. In implementing this expansion, Alabama did adopt the presumptive eligibility provisions that enable women to receive prenatal care as early as possible. Again, Congress is to be commended for including

this in that act. There is no resource requirement and eligibility continues in Alabama regardless of fluctuations in family income.

This year the expansion is expected to cost about $22.5 million. Governor Hunt requested and the legislature did include in the Medicaid budget sufficient moneys to continue this expansion. And I am glad to say that in the first 3 months of implementation, that over 4,000 additional pregnant women have been served under the Medicaid Program through this expansion. And almost 600 children have been added. I would like to say we are going to have to do a better job in getting the children involved, those children that are already born that are under 1 year of age. We are having a problem getting the parents to bring them in and making them eligible.

In addition to expanding eligibility, we are also improving services. One of the most innovative approaches, which we think is good, involves the new maternity waiver program in 13 counties.

Through this program, a single primary provider is responsible for a comprehensive system of pregnancy-related services to women who are eligible for Medicaid in a specified geographical area. This provider can be almost any entity capable of delivering the services or contracting for the services. For the services to the individual, from the first prenatal visit until after the delivery, Medicaid will pay a single fee to the primary provider.

This network of care includes outreach and case management, with the case manager assuring that the patient receives all necessary health care as well as social services.

Both the expansion of Medicaid through SOBRA and the maternity care waiver are expected to save money in the long run. You have heard testimony earlier that for every dollar spent on prenatal care, as much as $3 to $4 would be saved. By investing in prenatal care for the mother, we can avoid the cost of long-term care for children born with serious disabilities. And the maternity waiver program in particular should result in significant savings for neonatal intensive care because of the comprehensive nature of the services that are being provided.

Other program enhancements; as mentioned earlier, the Medicaid rate paid to physicians has been increased above the national average for Medicaid, not to say that it is above the national average for reimbursement, certainly not. As you are well aware, Medicaid reimbursement is significantly lower than private pay rates.

We are also allowing payments to pediatricians when called in to attend deliveries, which we had not done in the past.

The annual limit on hospital days has been lifted for maternity care only. We have a limited program with 12 in-patient days in Alabama and we have lifted that for maternity care to ensure access to care. This was again allowed by an exception to general Medicaid rules under the SOBRA legislation.

After months of negotiations with the Health Care Financing Administration, we think we are close to approval of an extension of hospital days for children requiring specialized services, such as neonatal intensive care. This would be through the use of donated funds.

I would like to speak to that. There has been some move in Washington to eliminate the use of donated funds in the Medicaid

Program. And I would encourage you to allow that, because in the States that do have low tax bases, like Alabama, there are some other means by which Medicaid services can be funded and allowing States to use donated funds to generate the State match is certainly a help in this State.

And MediKids, as Dr. Fox mentioned—we call it MediKids, the EPSDT Program, this is the screening that aids in early detection and treatment of problems. As Dr. Fox mentioned, we have been trying to increase those efforts. The number of children screened has gone up significantly. In 1986, we had one of the lowest percentages of eligibles being screened in the country, about 15 percent, and the number of individuals served was 25,000. That went up to 31,000 in 1987. When all the numbers are in for this year, we believe the number will reach about 40,000. The health department is to be commended for their efforts in that area.

Because care in the early years is critical, we are increasing the number of screenings for which Medicaid will pay. Next month we are going to raise the number of screenings to nine in the first 2 years of life, and this is the schedule that is recommended by the American Academy of Pediatrics.

While we have been improving services through Medicaid, we have also worked hard to educate the public and encourage widespread involvement in the search for solutions. Last year the Governor appointed a task force on infant mortality that remains very active. Most recently this task force is holding a series of town meetings around the State during the month of October and on into the month of November.

Earlier this year, the Governor held a symposium on infant mortality which was actually directed to leaders of business and industry. We had over 200 people attending, with many of those being the chief financial officers of some of the largest corporations that operate in the State of Alabama. And we feel that was significant in terms of educating them to ensure that when it came time to seek additional revenues from the legislature, that there would be support from the business community for that.

While much has been done, we realize that many problems remain, and we are working on those in cooperation with other State agencies, volunteers and professional associations.

During this administration, the high priority that has been placed on solutions will continue. That priority, insofar as Medicaid is concerned, is evidenced by the fact that this year we will receive $13 million more than the program has ever received from the general fund; that is more than a 10-percent increase in the overall program.

On the national level, Congress can help by giving States flexibility in administration of Medicaid Programs, more freedom to develop innovative solutions to complex problems. The SOBRA legislation is breaking the relationship between cash assistance and Medicaid and, I believe, is certainly an example of the approach we would like to see Congress continue.

In Alabama, there are some other things that we need to address, such as transportation. I certainly think there needs to be better coordination at the State level as well as from a national perspective of the section 18 moneys for transportation. Those

moneys, when they get down to the local level for administration, seem to serve only one purpose when they could be serving a number of the types of people that we are attempting to serve.

As I say, we have a—we also need to coordinate the services generally, whether they be child health moneys, WIC Program—in Alabama, I do not know if anyone is going to testify about it, but the Auburn extension service has started a program called MOM, Mastery of Motherhood. It is a very good program of education for generally teen mothers, but also other interested mothers, to assist them in nutritional counseling and just parenting classes.

As I say, we have a long way to go, but we are pleased with some of the progress that we have been making in the short term.

That concludes my remarks. I will be glad to answer any questions.

Mr. ESPY. Thank you, commissioner, we appreciate your presence and your testimony.

We will now turn to Dr. Pass.

[The prepared statement of Mr. Horsley appears at the conclusion of the hearing, see p. 87.]

STATEMENT OF MARY ANN PASS, M.D., DEPUTY HEALTH OFFICER, JEFFERSON COUNTY, ALABAMA DEPARTMENT OF HEALTH

Dr. PASS. I would also like to welcome you to Alabama and to Jefferson County. We certainly appreciate you being here, and I feel like we need your help on this issue.

I am grateful for the opportunity to share with you some of my concerns about infant mortality in Jefferson County. Infant mortality has a clear relationship to social and economic factors and is a health indicator used to measure differences in quality of life between areas. It is extremely important that we address this problem, not just because of the babies that have died, but because of the continuing morbidity and handicaps that accompany infant mortality.

Last year in Jefferson County there were 14,225 live births, that was about 24 percent of the total in the State. There were 10,052 births to county residents. The remaining 4,173 births were to nonresident women who live in other counties but who may have sought care in Jefferson County because of our doctors, our fine medical facilities or because there was simply no care available in their home county. In Jefferson County we are extremely fortunate to have the State's most sophisticated medical facilities, well-trained personnel to provide excellent medical services and a local commitment to provide care to low-income residents.

Among residents in Jefferson County in 1987, infant mortality remains much too high at 13.5 per thousand live births. This is above the State figure of 12.2, and much above the 1990 objective for the Nation. Higher than average infant mortality is typical for many of the large cities in this country. If we review carefully what has been happening, there has been little change in infant mortality in Jefferson County since about 1981.

One of the leading causes of infant mortality is low birth weight. Low-birth-weight infants are those born weighing less than 2500

grams or less than 5½ pounds. In Jefferson County in 1987, low birth weight occurred in 9.3 percent of all births. That was actually a slight increase over the 8.9 percent in 1986. Nationally, the percent of low birth weight is 6.8. A low-birth-weight infant has a 40 times greater chance of dying in the first month of life than an infant born at normal weight. Overall, about 60 percent of infant deaths can be linked to low birth weight. The rate of low birth weight is the most likely indicator that babies will not survive.

Factors contributing to low birth weight are varied. These include maternal characteristics such as very young or older age, black race, poor socioeconomic status, or unmarried status. There are maternal behavioral factors such as poor nutrition, drug or alcohol use, smoking, work/fatigue or other stressors. Inability to gain access to early and adequate prenatal care at the appropriate level of sophistication is also a major contributor.

According to the National Commission to Prevent Infant Mortality, the most effective means for preventing low birth weight is to assure that all women receive adequate prenatal care, starting early in pregnancy and lasting throughout. In Jefferson County in 1987, 114 women received no prenatal care, while 888 women received less than eight prenatal visits.

In Jefferson County, a system of prenatal care is available to low-income women. This system includes services at five major metropolitan health department clinics and at two satellite clinics in more suburban parts of the county. Delivery services are available at the University of Alabama at Birmingham and Cooper Green Hospital.

According to State Health Department calculations, most women with incomes less than 150 percent of the poverty level do enter this system. Unfortunately, many times the women do not come in early for prenatal care. In Jefferson County, 23 percent of women enter care past the first trimester.

We have also lacked resources to provide certain social support services. Few home visits have been made; follow-up for broken or missed appointments has been limited. Tracking of patients to assure entry into family planning services postpartum and for the infants into pediatric care has been dependent on very meager resources. We have taken care of patients on the doorstep with little recruitment of women into services. Our systems have changed very little since 1981.

In other areas of the country, case management services have been very effective in improving the quality of prenatal care and in reducing infant mortality. Although we have wanted to provide additional case management services in Jefferson County, resources have not been available in the past. With SOBRA expansion of Medicaid in July of this year and other statewide initiatives, those services are now possible.

Beginning October 1st in Jefferson County and in several other areas of the State, a Medicaid waiver program has been implemented. Under this program, the health department will be reimbursed by Medicaid for case management to those women under 100 percent of the Federal poverty level who are eligible for Medicaid. This will significantly improve the support services that we have at the health department and also allow improved recruit-

ment of patients, tracking, follow up and home visitation. All eligible women will be referred to WIC, the Federal Special Supplemental Food Program for Women, Infants and Children, as well as for specialized testing and high-risk care as appropriate.

The waiver is a partnership between the State Medicaid Agency, the Jefferson County Commission, the Jefferson County Health Department, Cooper Green Hospital, University Hospital, and the University of Alabama at Birmingham. This is the first major change to our system in many years.

At the local level, we are very grateful for the national, regional, and State initiatives that help us to have the resources to do our jobs. The Southern Governors' Task Force on Infant Mortality, the National Commission on Infant Mortality, the Governor's Task Force, the State Perinatal Program, the PARTNERS in advocacy, the Medicaid expansion and others, have all helped focus attention on this issue. And now with expansion of Medicaid services and implementation of case management, we are hopeful that we will have the tools to improve perinatal health and infant mortality.

Mr. ESPY. Thank you for your statement.

We will turn now to the final witness on this panel, Dr. Hale.

STATEMENT OF CHRISTIANE HALE, M.D., DIRECTOR, MATERNAL AND CHILD HEALTH TRAINING PROGRAM, UNIVERSITY OF ALABAMA AT BIRMINGHAM

Dr. HALE. I would like to join with everybody else in welcoming you to Birmingham, and to thank Congressman Erdreich for his very kind words about UAB.

UAB is a world-class medical center and I hope you will understand as I go through my testimony the sense of dissonance I have reporting the findings I am about to report in a setting of such late 20th century high technology. Essentially these are findings that one would expect to find in a developing country, not in the United States.

What I want to talk about today is post-neonatal mortality, or death to infants who have survived the first month of life. With the exception of the very rare tragic case of a child with a lethal congenital anomaly or some other life-threatening condition, parents have every right to expect a child who survives that precarious first month to be with them for some time.

The figures I am going to give you come from a study of nearly 1,000 deaths to infants in the last 11 months of this first year, born in Alabama between January 1, 1980 and December 31, 1983. I want to say two things about the study before we start. First, although the numbers are small, it appears that for each year; that is, between 1981 and 1982 and so on and so forth, matters worsened. More babies were dying and more of them clearly did not have to die. There is very little that has occurred since the study period that leads us to believe that this trend has disappeared.

Second, the figures I am giving you are minimums. I, at least, am by no means certain that all infant deaths in Alabama are reported. Ten years ago, investigators in Georgia found that 20 percent of infant deaths had not been reported, most of those in the

rural areas that are poorly served generally. A similar pattern may exist here. There has never been an assessment of it.

Having said all that, we found that in Alabama, among every 1,000 normal-birth-weight babies, these are the so-called good babies, who had survived the first year of life, two white babies and almost five black ones died subsequently. Among moderately low-birth-weight babies, the ones who weighed between 1,500 to 2,499 grams, where survival generally is pretty good, post-neonatal mortality rates are 11 per 1,000 for whites and 16 per 1,000 for blacks. The racial difference that you have heard alluded to before certainly showed up in our study and I have some comments I am going to give you about that in a few minutes.

We found that infants born to women living in Alabama's 49 nonmetropolitan communities were significantly likelier to die than those born to women living in the 18 metropolitan areas.

Infections were a major cause of post-neonatal death. Nearly 20 percent of the deaths to black infants and about 13 percent of the deaths to white infants were caused by infections. Gastroenteritis and pneumonia—and this is in the late 20th century—were the principal infections noted on the death certificates. We consider deaths from injuries and from infections to be preventable. Using this classification almost a third of the deaths to the normal-birth-weight babies and 18 percent of the deaths to the moderately low-birth-weight babies were preventable. These figures are absolute minimum estimates. We knew that some babies whose deaths had been classified as SIDS or from unknown causes had actually died from infections or injuries and we did not make any effort to put that into our figures. We tried to make the most conservative estimates possible.

We believe that the excess mortality experienced by infants living in rural counties may actually reflect the lack of access to health care. And in many instances, it is not access, it is the mere availability of health care. We base this statement on our finding that the number of prenatal visits is a strong predictor of post-neonatal deaths. In fact, virtually all the observed excess risk among rural infants and much of the excess observed among blacks disappears when the number of prenatal visits is controlled.

Prenatal care is so far removed in time from a post-neonatal death, that the argument for direct causation cannot be sustained. Prenatal care is probably a surrogate for something else and we believe that something else is health care, particularly well child and sick child facilities.

I want to say a couple of things about the black elevated risk of infant mortality generally. The black elevated risk exists throughout the United States in every place and in every time period in which it is studied. Even controlling poor education and maternal age, black women are still twice as likely to lose their babies as white women. The most promising line of thought right now considers race to be measuring the risk of inter-generational poverty. That is the risk of having been born to a poor mother who was herself born to a poor mother, on and on in a chain. That is a pattern of poverty that does not characterize whites, but does characterize blacks.

We also think that what we are seeing with the post-neonatal findings is that more blacks are likely to be poor than whites. Not only is poverty itself a risk factor for post-neonatal death because the water supply is contaminated or the housing is inadequate or the nutritional status is minimal, but being poor itself makes a woman and her children utterly dependent on public health services. Where those services exist and are good, the women and children are well cared for. But where they are inadequately funded or do not exist at all—I would suggest those are characteristics that could apply to places in Alabama—the mothers and children suffer. And our study documents the extent of that suffering.

Finally, we have a couple of conclusions from these findings. First of all, the child survival Program of the World Health Organization, with its four-pronged emphasis on immunizations, breast feeding, growth monitoring and oral rehydration may have application in the United States, it may simply not be limited to developing countries, and it may be that there are places in the United States that so resemble developing countries that we need to give serious consideration to this program. Alabama certainly appears to be one such setting.

The second conclusion is, as Congressman Erdreich noted earlier, that the United States varies greatly from other developed countries in terms of its infant mortality. What is even more shocking is that the variation among the 50 States is greater than the variation between the United States and all other developed countries.

Hearings like this have to be held in a State like Alabama because its performance is so much worse than everybody else's. That I would suggest occurs when there is a lack of political will at the top level, so that instead of having a single national standard, 50 fragmented systems are allowed to develop. That concludes my comments.

Mr. ESPY. We have received superb testimony from each one of the witnesses. I could not agree more with Dr. Hale's statement that here we sit in the America of 1988 and 1989 and we find these shocking statistics on low-birth-weight babies and infant mortality. In contrast, if you look at Cuba and Costa Rica, and some of the other South American countries, you will find that they are all doing better than we are. It is a matter of priority and it is a matter of commitment. And that is why we are here.

You know, we could sit in Washington in the ivory tower and look at public health statistics, but it is really incumbent upon all of us to get out into the States, particularly those States like Alabama and Mississippi that have such severe problems. It is certainly time we started to do something about these situations.

As I said in my opening statement, we were in Mississippi during the early part of the session. The committee had also visited the State in 1984. The committee's focus on the need to alleviate the infant mortality problem in Mississippi and other high-risk States led to the creation of a $600,000 grant program for the monitoring of severe pediatric undernutrition. Mississippi, as a grant recipient, is establishing a surveillance system in some of the high-risk counties in my district. We are here and we are here for a purpose, hopefully to secure similar interventions in Alabama.

I am going to keep my questions very brief because we have another panel and I am sure Ben and Claude have specific questions relative to Jefferson County and the rest of Alabama. I do have a couple of questions though of Dr. Fox.

Currently the State provides no supplement for the Federal allocation for the WIC Program, and I just want to ask you, does the State of Alabama have any plans to provide such supplemental funding for that program?

Dr. Fox. Mr. Congressman, so far as I know there is no plan on the part of the legislature to provide any supplement for the WIC Program. We are going to be faced with this year—and it is a pleasant problem to be faced with—trying to spend our rebate. We have gone from having some $25 million or so dollars to spend on the food program and now having $10 million in addition to that. So we are going to be working to try to use that up. As you are probably aware, the Federal allocation formula actually penalizes a State if they do not spend their allocation, so we are going to be trying to spend our regular allocation plus the other. But we do not have any insight into the State planning to put up any State money.

Mr. ESPY. In your testimony, you talked about a regionalized system of health care that you have established through your department. As a Mississippian, give me some sort of an idea of which components are operational and which ones are lacking; where in the State they are located; and, what plans you have to establish a more equitable geographic distribution of your health care programs.

Dr. Fox. That is quite a question.

In a regionalized system, the way I envision it, we would have basic low-risk services available in every county, and that would be basic prenatal care, basic pediatric services, those types of things should be available in all cities and all counties in the State. That is not necessarily true now. We are establishing those through the county health departments.

But we should have the specialized services, specialized delivery services, and infant services available, particularly in hospitals only in what we call secondary or tertiary level systems, and those would be available in places like Birmingham, Dothan, Anniston, other cities.

The problem we are having now is two-fold; one, because of the failure of physicians to maintain an involvement in OB and pediatric care, we do not even have the low-risk care at the county level. We will never have deliveries in every county, we will never have high-risk services in all counties, but we should have basic services. And we do not have that now because of the malpractice problem and the distribution of providers. That could be solved I think by maybe making supplements on malpractice premiums for physicians who will relocate in a rural area or maybe who have gotten out of OB and still live in that rural area, but will get back in.

Representative Ron Johnson in our legislature did have a bill for that in the special session and I think it will be coming back in the regular session. I think that would be very positive and would remove the financial penalty for a physician to do OB in a rural area, as far as malpractice is concerned.

The second thing is we do not have a training program for certified nurse-midwives. Mississippi had one, Alabama does not have one. Mississippi's has been phased out, but we feel like—I certainly feel like we need a training program in the south other than Emory for certified nurse-midwives, and we need to be training our own nurses that can go in and work with an obstetrician in the local community to provide delivery services. And that is certainly something that I think needs to be looked at in Alabama.

So those would be some things on the short-term that we could do in trying to rebuild this system.

Mr. ESPY. Thank you.

I will turn now to Commissioner Horsley. I want to thank you as well for participating and for expressing the Governor's attitude with regard to the problem. We know that he has been involved and he continues to be involved in the expansion of the Medicaid Program that has allowed for a greater number of pregnant women to have access to health services, but just as Dr. Fox and others have testified, this expansion is fruitless for women who do not have access to either a practitioner or to a practitioner who accepts Medicaid or to a public health clinic of some type. So what is the State doing to ensure services for women in these situations?

Mr. HORSLEY. Obviously, as Dr. Fox stated, there is concern with malpractice, which has driven not only obstetricians out of the business of delivering babies, but family practitioners who had in the past in the State of Alabama delivered babies, and that is a serious concern.

The legislature and the Governor in the last—not this past session, but the session before that—did pass tort reform legislation. I do not think that is going to have a significant impact for 3 to 4 years in terms of premiums. In fact, the major carrier in this State has just requested a 21-percent increase and I think the insurance commission is going to grant something in the neighborhood of a 14-percent increase for OB malpractice premiums. So that is a significant problem.

One thing that I would like to see addressed is if Medicaid were given the flexibility to cover the malpractice portion for the Medicaid population; that is, those that are below 100 percent of the poverty level, and remove that risk from the population that is served by us. There are a lot of mechanics that would have to be worked on in dealing with that. I have talked with our insurance commissioner and others. I am not sure from a Federal standpoint whether I have the flexibility to separate out that portion of payments for malpractice premiums and ensure that we remove the risk. But I think it is going to have to go further, I think our legislature would also have to address it in terms of some type of limitation of liability in addition to that. And perhaps pool that money in perhaps a no-fault type system. I know two or three States have addressed that from a no-fault standpoint in terms of malpractice.

I think that should, in the long run—and that is not a short-term solution—in the long run may address access to care in areas of the State. As Dr. Fox said, I do not think we are ever going to be able to have a practicing obstetrician in every county in this State. I am not sure that is a goal that we should even be striving for. As he said, we do need to ensure that we have adequate prenatal care

and low-risk care as well as pediatric care available in every county and we need to be striving for that.

Other areas, of course you know, Medicaid reimbursement is low in Alabama as well as it is low in a lot of areas of the State—I mean in the country. In comparing our reimbursement to other States in the Nation though, we are average on some, we are a little bit below average on others. But for a State, given the per capita income level of the State of Alabama, I think that is significant that we do maintain those levels up pretty good. Studies that have been done indicate that the payment level in and of itself is not a significant contributing factor to the denial of access in Alabama to Medicaid recipients. We have pretty good participation by physicians in this State, and I am glad to see that they are willing to participate in that program.

Mr. ESPY. Your suggestion with regard to medical malpractice premium reimbursement is interesting and we really would like to follow up on that and hear a little bit more about it.

All we have talked about here, if you reduce it to its basic essence, is the fact that we need more money to expand the services. The Federal Government needs to come in and do more, the State needs to do more. We all know that is a matter of money and when you talk about money, you talk about problems. In this country we are still running a significant Federal deficit. It is not a party problem, it is not a policy problem, it is an American problem that we all need to deal with. The pie is getting smaller, the portions are respectively growing smaller and we have competing considerations for competing programs. So, we have to create innovative solutions from States and from commissioners such as yourself.

It has come to my attention that you proposed an innovative program to fund the SOBRA expansions through contributions from a voluntary checkoff on the State income tax forms. I am interested in knowing how far you have gotten with this. I am curious because this is, to me, basically a funding mechanism that would be inconsistent because it is relying upon uncertain contributions from year to year solicited to a voluntary fund.

Mr. HORSLEY. A trust fund was established. We did not go with the idea of a checkoff because there were a lot of checkoffs already on the Alabama income tax form, and studies indicate that there is a limited pool available and that all you do with a checkoff, when you add one more to the checkoff, you just diminish the amount going to each one that is drawing from the pool. So we did not go with that idea.

In fact, right now the only anticipated use that we have for that indigent care trust fund is to remove the limitation of hospital days for pediatric patients. And through that, what we anticipate doing, and I do not think it will be in a limited measure—or limited resource pool to draw from—actually the hospital that will be participating in the program will be making donations into the program as well as other donated funds coming into it. With that we will be drawing the Federal match so that even if the only contributions we received were from hospitals in the State of Alabama, they would be receiving 73 cents on the dollar, where they have been receiving zero in the past. So it is obviously to their benefit to continue that type of funding arrangement. It is one way that we can

expand, and I believe to address a small number of our patients. Of our Medicaid patients 97 percent are actually served with the 12 day hospital stay that we allow. But the other 3 percent are the high-cost individuals that in terms of extended hospital days have extremely high medical costs, and those are the ones we want to address with this system of donations. I think it will actually work in that way.

I am not sure that relying on a checkoff system—I never really advocated that, that was proposed by some others to say that might be a way to get some increased funding. I do not think that is a good way to do it. And we were looking more at local governments contributing, local governments that have—Jefferson County, for instance, I think puts in the neighborhood of $18 to $19 million into indigent health care in this area. If that is matched with our matching rate in Alabama, which is 3 to 1, that $18 to $19 million has expanded tremendously and serves a great deal more.

So if we could tap into those available resources that we are already using to address indigent care in the State and be sure we are maximizing the Federal Medicaid dollar, I think it would be worthwhile.

Mr. ESPY. Thank you. I have some other questions, but at this point I am going to go to Ben.

Mr. ERDREICH. Thank you, Mike. I want to thank all the witnesses, I thought the testimony was excellent.

Let me start with Dr. Fox, just a couple of follow up questions to your testimony. Dr. Fox, you mentioned that in fiscal 1987, the health department had adopted what you called core services in every county providing prenatal and child health care. Do you have any figures or results of what that accomplished in the short time it has been in place?

Dr. FOX. Congressman, we do not have any mortality statistics yet, but we did see within the first year our number of patients receiving prenatal services go up by 10 percent statewide, which I do not think is any small increase considering the fact that we were already serving between 25 and 30 percent of all pregnant women to begin with. So we did see a large number of women that I feel were able to get in for care and hopefully we will have a better outcome, so we have some process indicators but we do not have the outcome indicators yet.

Mr. ERDREICH. You mentioned, which I think we all agree from the congressional view, that we have too many obstacles to entry and too many varieties of programs. Is there any idea or suggestion today or after today that you could give the committee that would give us some ideas that you have and the State may have to provide a single entry or elimination of most of the obstacles. I realize we have different programs that have different requirements and so on involved in this area, but if you have some ideas off the top of your head or if you might have some well-thought through, but I would like to hear about that later, it is something I would like to pursue at the Federal level.

Dr. FOX. Well, just briefly, I think there is a need for some attention to eligibility standards. The eligibility standards for family planning, for WIC, for maternal child health, for AFDC—Aid to Families with Dependent Children—all those eligibilities are in

general different, and there are other eligibilities. And I think there is a need to look at a common eligibility standard, a single eligibility process. I am not necessarily an advocate of all the programs being lumped necessarily under one administration because you get into some problems there. I do not think that bigger agencies are necessarily better, but I do think there should be some common eligibility standards used and these in many instances would have to be mandated from the Federal level because all we are doing is reacting.

That would make all of our lives easier. We are spending countless hours, paperwork, time of our personnel, time of the people coming in seeking services, filling out eligibility forms at all the different agencies that are different when they could be the same.

Mr. ERDREICH. Dr. Pass, let me ask from Jefferson County's viewpoint, not only that question, but I was interested—you said that a look at figures in our county indicate very little change since 1981. Do you have any idea as to why we have made little or no progress since 1981 regarding infant mortality?

Dr. PASS. It was about that time that the Federal block grants came into effect and we actually had cutbacks in Federal dollars coming to the State.

Mr. ERDREICH. So block grants were a block of less money for you to use.

Dr. PASS. Yes. And it is very interesting that in Jefferson County last year 65 percent of the dollars that we used for maternal and child health care Programs were local dollars. We only got 35 percent of our operating dollars from the maternal and child health care block grant, which is Federal and State dollars.

Mr. ERDREICH. Let me ask you another one and then I will cut this short, I enjoyed all of your testimony—but let me ask Dr. Hale who—I was hearing that everything was going so well from the other three witnesses and then Dr. Hale put some cold water on some of these assertions. But as a critical and I think very objective observer of what is going on, are we dealing here with a financial problem? You know, we hear if we get more money we can solve this, that comes to us I guess from all levels of government. Are we dealing with a health problem or a political problem, or all three?

Dr. HALE. Well let me answer from the national perspective first. Infant mortality is not a health problem. One of the reasons it is such a fascinating thing to study is precisely that. It is a social problem which has a political solution. And that is true in Alabama as well. You have heard people talk about Alabama has no money—well part of the reason Alabama has no money is that its State tax structure virtually mirrors that of developing countries. Landowners are encouraged to hold their land fallow, they pay lower taxes on it if they do so—they will overlook the fact that of course they create no employment opportunities. One of the most ironic things for me is to go into the grocery stores here in Birmingham. Here is a State with a three crop growing season and the produce is all imported from California and Texas and other places. That is a consequence of a tax policy which encourages people to put their land into pulpwood or not to do anything with

it, or to grow large crops such as soybeans for export. So that in a sense, there is a political piece of this.

However I also feel compelled to point out—and those of you who have read David Stockman's book know about the shell game that was played with the maternal and child health block grant in which he made up a number, estimated that to be the cost of administering the old categorical programs and subtracted it from the MCH block grants. That little exercise was followed by great inflation. Now we are down to something a little bit more tolerable. However, that was also the period associated with what was called a recession, which under other circumstances might have a different title. That recession hit Alabama very, very hard. There were places that were running 20 and 25 percent unemployment. Some of those pockets still remain and some of those families are now re-employed but they are re-employed in jobs where there is no health insurance or where the health insurance covers the adult but not the children or excludes pregnancy, all of which are legal devices, I might point out.

So then there is an issue of money, but it is not an issue that can simply be solved by the Federal Government writing a larger check. It is a problem of political will, it is a problem of commitment on the part of the people left to spend the money, it is the fundamental problem I suggest that you get in a country that cannot decide whether health care is a right or a privilege. We have obviously decided that if you live to be 65, health care becomes a right, that is what Medicare is all about. There is a great deal of disagreement about whether it is a right prior. I think that is something that the Congress is going to have to sort out.

Mr. ERDREICH. Thank you very much, I appreciate the testimony.

Mr. ESPY. Claude.

Mr. HARRIS. Dr. Hale, I think you just put the hammer right on the nail. You know, I just wonder—we talk about economic development and we know that that is a way that we can help break the cycle of poverty if we bring in jobs and give people meaningful employment. And we talk about our strategy in trying to attract industry to do that, and we know that one of the things that an industrialist is going to be looking at besides education, is the health care system. So I just wonder, and I would ask any of you, do we have a strategy at the State level or any level that you know of, as far as trying to attract doctors to these rural areas in particular, where we seem to have our biggest problem. Do we have one, and if so, what is it?

Dr. FOX. Congressman, I do not think there is a coordinated strategy, there are things that are going on in various groups, and I will just give you one instance. We have been working with an industry down in Russell and Barber Counties to go in and set up on a short-term basis a health care site to bring in local industry and provide health care services. And this is certainly a role that I think the health departments can play.

But a strategy as far as recruiting physicians, we need to look at our State scholarship programs. We are going to be much more successful finding folks here in Alabama that want to go to medical school or go to professional school and would be willing to stay. And I think we need to look perhaps at expansion of our State

scholarship program that would keep some of our Alabama natives back in this State and perhaps do a better job of retaining folks there.

One other thing that might should be looked at on a national level, and I hesitate to say this, but it is the idea of rather than a national health service corps that is depending on scholarship recipients, a national health service program that would require all professionals of health schools, whether it be occupational therapists, physical therapists, nurses, physicians, social workers, to spend 2 years in public service prior to going into their private practice. And that would be a useful tool where people could be placed in rural areas. Some would stay, many would not, but even if only 1 out of 10 stayed and we had a requirement for that, it certainly would provide some manpower to provide health services in the rural areas.

So I think a combination of things there. The national health services corps has had I think some success, limited somewhat, in that a lot of the national health services corps come from out of State, they do not stay, they leave. There are a few folks, and some that you will probably hear from today, that have stayed, and certainly in some ways it is successful, but I think if we could grow our own in addition to maybe looking at a national health service that would really apply to everybody—and that is a problem that I have had in the past, if we were to do something like that it would need to be applied uniformly.

Dr. HALE. I want to add something to what Earl has suggested. People are going to raise eyebrows at the notion of compulsory service following professional school training, but the fact of the matter is that they are being trained with public revenues. Every health professional training school, public or private, should be able to give you an estimate of what proportion of the tuition and related costs for their students come from public sector funds. This is not nearly as radical as it sounds, it is simply paying back what the people got.

Mr. HARRIS. Are you suggesting that maybe as a payback, rather than in dollars, they he pay back in service?

Dr. HALE. Yes, I am. I am suggesting a uniform requirement. And again, this is something that would have to come as a national policy.

Mr. HARRIS. Does anyone else have any thoughts on that? That's interesting.

Dr. FOX. The only comment I would say is do not make it apply only to physicians.

Dr. HALE. Right.

Dr. FOX. You know, for a physician to do their job, they have to have the other health personnel out there. And I think again the problem that you might encounter would be if it only applied to selected people or to selected professions. I think if you could apply it to health professions overall, you would generate a huge cadre of health professionals that could be put in the States in rural areas to provide service. If everyone knew they had to do it, they had to do it for 2 years, you just planned on it, it was a part of your process, and at the end of 2 years you went on and did whatever it is you wanted to do with your life, but that was just an obligation.

Because very few people go through health professional schools in this country now without the use of some public funds, Federal or State.

Mr. HARRIS. Thank you, Mr. Chairman.

Mr. ESPY. Thank you. I just want to ask the panel whether any of you are familiar with the welfare reform bill that was passed last week in the House and Senate. Is anyone eager to offer an analysis of it? I am sitting here listening to the testimony, particularly to Dr. Hale, where you found in your research on post-neonatal mortality among normal-birth-weight infants, that a majority of the deaths were probably preventable. That is just a sad commentary of where we are.

Within the legislation that we passed last week, otherwise known as the welfare reform bill, there is a provision that takes place—I do not think it takes place before 1994 though—that requires a welfare recipient in a two-parent family to obligate himself or herself toward some level of community service if there are not any jobs available within the community.

I was thinking about other countries where they have literacy squads where they go forth and they teach a cadre of individuals how to teach others to read. I was thinking whether or not we, Ben and the Judge on our level, could encourage the Congress to consider some sort of an infant mortality squad, if you will, where you go forward and you spread the message on nutrition. Do you have any ideas on that?

Dr. HALE. I mentioned the World Health Organization's Child Survival Initiative. That is one very much like the kinds of people you are talking about, women who go out and visit with other women and teach them, for example, to use oral rehydration. Now oral rehydration sounds like this terribly exotic technique, it is simply putting some water and sugar into—some sugar and salts into good water, the key here being good water.

Many of these deaths that I am talking about were gastroenteritis deaths, they are dysentery. Those could be prevented by this kind of training. I think, too, that one of the problems in the rural areas is contaminated water supply. The kind of cadre you are talking about could have an influence on that. The drought certainly has affected the supply of water, it looks as if a lot of waste and drinking water is getting mingled.

I think it is a great idea. I think if you wait until 1994, this country will have the distinction quite probably of entering the 21st century with the worst infant mortality rate of any developed country, we are not that far away now. We are 17 out of 21.

Dr. Fox. Mr. Chairman, if I just might comment, I think one other thing that could be done in the way of welfare reform is further unlinking of Medicaid from welfare payments. My experience is that many people that have small children go after a welfare eligibility not so much for the payment as for the medical coverage for their children. The reverse is true, they may be hesitant to come off, go get a job because they lose that medical coverage, and if you have a small child that has multiple ear infections, that is a problem.

The SOBRA expansion, I want to compliment the Congress on taking a first step for pulling those two programs apart, and I

think that it certainly has impeded the Medicaid Programs in all States, just being tied to the payment program. And I think those issues both are important but they need to be viewed separately. So I think further efforts to unlink Medicaid from a cash payments system would certainly be positive for this country.

Mr. HARRIS. There is a provision in the bill for a carry-over period when they go to work.

Mr. HORSLEY. Twelve months. And I think that is an excellent provision. It was one—we have been working on welfare reform in the State for some time, and we were seeking a waiver to allow that, but now we will not need that waiver now that this is in the welfare reform package that came out.

From an anecdotal type of statement, my wife had an employee who quit her job because she was a single parent with two small children. One of them has some severe health problems, and I hate to say it, but the mother was an employee of a hospital in the State of Alabama that did not provide health insurance for all of their employees. She resigned from that job to go back on ADC so that she could provide for the one child that had the health problem. That is something that we do not need. And that is something that I think can be addressed through this program of providing Medicaid for an extended period of time and perhaps a means in the future of allowing lower income individuals to perhaps buy into Medicaid as an alternative to private health insurance, if that is an option that could be a less costly option to those individuals.

I am not sure that I, as the administrator of the program, want to get into the insurance business, but I think that is perhaps a viable option that we might need to research and see if it could work in the future.

Mr. ESPY. Thank you, commissioner, and thank all of you for being here this morning and for your absolutely excellent presentations.

Let us go next to the last panel of four individuals. I would like to call to the witness table at this point Ms. Martha Jane Patton, Dr. Sandral Hullett, Ms. Emily Bentley, and Ms. Sabrina Colvin.

As an introduction, Ms. Patton has been instrumental in bringing attention to the problem of infant mortality in Alabama. She is the corresponding secretary of Foundation for Women's Health and a member of the Governor's Task Force on Infant Mortality, the Alabama Task Force on Prevention and Perinatal Health and the Mayor's Commission on the Status of Women.

Dr. Hullett is the health services director of the West Alabama Health Services Agency. She has the difficult task of providing perinatal services in the area of Alabama experiencing the highest rate of infant mortality. As health director, she has initiated innovative measures to combat infant mortality in rural Alabama.

Ms. Bentley covers State politics for the Alabama Journal. As a native of Alabama, she is well acquainted with the problem of infant mortality in this State and has the distinguished honor of having been a member of a team of journalists who won a Pulitzer prize for a series of articles on Alabama infant mortality.

Ms. Colvin is the mother of a 4-year-old child and just 4 months ago gave birth to another healthy baby. If that was the child you

had in here this morning, we can vouch for the fact that the child has healthy lungs. [Laughter.]

Six years ago she lost her first child as a result of a premature delivery. I would like to extend my warmest welcome to you for coming here today and for telling us your story.

Let us start with Ms. Patton.

STATEMENT OF MARTHA JANE PATTON, MEMBER, GOVERNOR'S TASK FORCE ON INFANT MORTALITY

Ms. PATTON. Mr. Chairman, Congressmen Erdreich and Harris, I am pleased to participate in this hearing this morning as a member of Governor Hunt's Task Force on Infant Mortality. This task force has been in existence for about a year, having been formed in the fall of 1987. The chair of it is the Medicaid Commissioner Michael Horsley, who just was on the previous panel.

The task force consists of a diverse group of individuals who were appointed by the Governor who have demonstrated their commitment to solving this problem in our State. Members of the task force were drawn from the legislature, State agencies, county and city agencies and governments, physicians, nurses, insurance and business executives, and private volunteer groups. Many of the organizations that are represented in the makeup of the task force were catalysts in its formation. For example, I think Dr. Fox referred to the predecessor task force that he established on prevention and perinatal health which had already concerned itself with this serious problem facing our State.

Other efforts had been launched several years ago by a coalition of organizations who first met together to celebrate the anniversary of title V of the Social Security Act, which created the block grants for maternal and child health. This coalition which calls itself the Partners for Improving Women's and Children's Health in Alabama and I believe was referred to by a representative earlier today, originally consisted of three groups; the Alabama Advisory Council on Maternal and Child Health, the Alabama Perinatal Association and the Organization that I represented, the Foundation for Women's Health in Alabama. The "Partners," as we have come to be known, has since been joined by many other organizations such as the March of Dimes and has been an effective information source and lobbying force, especially in the areas of securing adequate funding for preventive health programs. I have attached to my report today for your information several speeches and other documents that have been either given to or been generated by the various partner organizations.

These catalyst organizations created a solid history of concern and focus on this issue and out of that the Governor's task force has made several significant accomplishments toward the goal of better health for Alabama mothers and babies. The task force has now met four times; in November of 1987 and in January, May and July of this year. We have divided ourselves into four work groups; the first being education and awareness, second is service delivery, third is finance, and fourth, research.

Among our various accomplishments so far we have shared with each other and our various represented organizations all of the sci-

entific, medical and statistical literature that we can locate on the issue of infant mortality. In particular, the publications of the National Commission to Prevent Infant Mortality, which is chaired by Senator Lawton Chiles.

Second, we have promoted and publicized the new eligibility standards for our expanded Medicaid Program available under SOBRA. We have done this through brochures, through posters, town meetings and other various public relations methods. I have attached to my report today, a schedule of these meetings which will take place over this month and next in nine different locations throughout the State.

Third, we have—through our various organizations, we have pressured the legislature to support the full funding for prenatal and preventive health care.

Fourth, we have acted as a sounding board for controversial subjects, such as the solutions to the growing malpractice insurance crisis in our State.

Fifth, we have continued to monitor the progress of our State toward lowering infant mortality rates.

Sixth, of course we have educated each other about various local programs throughout the State that have been effective.

And last, we have participated in the Governor's symposium which was held January 28 of this year, and this symposium was directed to the role of business and industry in solving these State problems.

The task force has effectively established itself as a multidisciplinary forum, and through that method it has been able to imminently address the problems in a comprehensive way. We intend to identify the multiple issues that affect the issue of infant mortality, and I will mention a few of those such as the need for rural preventive medical care, the problem of nurses, funding for case management, malpractice insurance problems, the maldistribution of health care workers, the future role of family practitioners, the obstetrician shortage, and the societal attitudes that may block effective solutions to this problem.

We do not consider ourselves a data-generating body in that we believe the extent of the problem, as you all have heard this morning, and many solutions, have already been addressed. We will continue to invite knowledgeable persons to appear before us and make presentations. We will conduct the town meetings throughout the State and present the information that is gleaned from these sources to the proper governmental bodies for action.

In summary, the task force represents a significant step toward reducing Alabama's high infant mortality rate. Being a member of the task force has afforded me an opportunity to solidify and act on my own commitment and that of the organization that I represent, the Foundation for Women's Health in Alabama, and to participate as a health care consumer, in the decisions that affect the lives of myself and my neighbors.

I thank you very much for the opportunity to share this experience with you and the members of the Select Committee on Hunger. Our task is to stop the deaths and health problems of Alabama mothers and babies, and the force is us.

Mr. ESPY. May the force be with us. Thank you.

Dr. Hullett.

[The prepared statement of Ms. Patton appears at the conclusion of the hearing, see p. 100.]

STATEMENT OF SANDRAL HULLETT, M.D., HEALTH SERVICES DIRECTOR, WEST ALABAMA HEALTH SERVICES, INC.

Dr. HULLETT. Mr. Chairman, Congressmen Erdreich and Harris, I would like to thank you for allowing me to share some of my thoughts and experiences with you on infant mortality in the west Alabama area.

The west Alabama area is a beautiful part of the State, it is called the black belt and it is called so because of the rich black soil that passes through the area. It once was a very large cotton producing area, now is an area of primarily catfish farms and cattle farms, and a lot of unemployed people and very, very poor people. In fact, it is one of the poorest areas in the State, has one of the two counties that rank fifth poorest per capita in the Nation. That is just to let you know the poverty of the area.

We also have noted, as Dr. Hale stated earlier, that infant mortality—infant and neonatal mortality is greater among blacks, and we find that among rural blacks it is twice as high, and the morbidity rate is even higher. We do not know exactly what caused this, we think it may be because of the lack of education, the poverty in the area, the isolation that exists in some areas, the inappropriate health behavior and failure to seek medical assistance when needed. Often the mother's lack of knowledge and behavior patterns are passed on to the children with consequent continuation of the cycle. And this is just a follow through of something Dr. Hale has said.

West Alabama Health Services is the community health center based in this area and we have our catchment area which covers five counties; they are Hale, Greene, Sumter, Marengo, and Choctaw. However, we do have sort of a consortium agreement with the district health department in our area that now has us working with more counties. In fact, there are about 10 counties; the additional counties are Bibb, Pickens, Lamar, Fayette, and Tuscaloosa.

The West Alabama service area has historically had a very high infant mortality rate. In recent years, there has been some improvement for the area, although the small population base lends itself to a spiking statistical profile.

The most dramatic improvement for 1986 occurred in Greene County where the rate fell from 39.9 per thousand live births to 5.5 per thousand live births, one of the five lowest in the State at that time. West Alabama feels that its maternal and early childhood health programs, centered in Greene County, may have been a major factor for the decrease that I just noted.

Even though we did have a significant decrease in that year, 1986, we did go up in 1982, that was because of two deaths instead of one death. You are talking about very small numbers here. But our overall 5-year rate is 18.7, which is still significantly high, when the State is 12.2.

Improvement is a slow process involving specialized care and educational programs. Rates will continue to fluctuate dramatically

because of the widespread poverty, poor health habits, and a small statistical base. In my testimony, there are statistics to show what I am talking about.

Mr. ESPY. We will include the testimony in its entirety in the record.

Dr. HULLETT. I think the statistics are important for you to see, so you can see some of the changes that have occurred.

In the perinatal mortality rate, although the area continues to have a high rate of death of fetuses of 28 weeks or more gestation, this too has improved, and in fact Greene County now has registered more than 60 percent below the State average, so we still are making significant improvement and even with these significant improvements we are still experiencing very high rates.

The challenge to us is how can we address these problems. We want to improve birth weight. We have found, interestingly enough, that in the last 2 to 3 years that we have been collecting data, that the birth weight of our babies is not very low. So that seems to be kind of odd when you think about the high rate of infant mortality. But we feel that the WIC Program and the Food Stamp Program have increased the nutrition to our women in general and therefore the babies are not as small as they have been. We still have a large number of the early babies, as I stated before, in gestation down to about 28 weeks but the low birth weight is really significantly low.

Congenital anomalies in our area are also low, but they still exist. Some of the problems that we—our major problems occur within the first year of life and the babies are dying at the highest rate within the first year of life. So therefore, we are working on improving parenting skills.

Some of the strategies of West Alabama have evolved and one of the most significant ones was originally funded by the Ford Foundation under the Child Survival Program, and we implemented a program of using lay home visitation.

In this particular program we used women from the community. These are not college educated women, these are not nurses. These are women from the community who are genuinely concerned and interested, to go out and work with young mothers. We originally started with first time mothers, but did not have enough because of decrease in teen-age pregnancy in our area from the time that we wrote our grant. Again, we felt this was a part of some of the special programs that we have. So we involved young mothers, and found that the young mothers had—mothers who had three children had as many problems as young mothers who only had their first child.

These lay women functioned in areas of nutrition education, in getting the women to come in to prenatal care, and generally act as emotional support. And I think that is probably the most important thing.

Some of the things that we found; the women that were in the program had a higher number of prenatal visits, and they did very well during their prenatal course and delivery course and had a tendency to bring their children in more frequently after birth for follow up. We did follow these women for the first 2 years of life.

This program was very efficient—effective and efficient. And this is something I think we should look at on a State and Federal basis, using things that are cost-effective and that work. These women were paid minimum wages. And in an area where there is a lack of professionally trained people and in an area where socioeconomics is a real problem, this is another very good way of expanding health services.

There are a couple of other programs that I did not put in my testimony, that I will just mention briefly. One is the Women's Health Consortium, which is a combination of a rural community health center, urban community health center, district health department, and the Federal Government in that the National Health Service Corps obstetricians and gynecologists were given to us—we obtained them through that service. In this way we are able to give high-risk services to as many as 14 counties and the women who are designated as high-risk are referred into GCH Hospital for their delivery and we use the district health department as our base. This is a situation where we are combining resources with the health department and the community health center and a Federal program and a State program to give the needed care to a very large area of women. We would like to see programs like this expanded and moneys made available for such programs.

As we improve nutrition and the ability to pay for services and have no providers or hospitals sites in small towns, we still have grave problems. The culprit in this case is malpractice in the State of Alabama. Some changes must occur State and nationwide. There are at least six counties in the surrounding catchment area who are delivering no OB services. Dr. Fox stated earlier there were 28 counties in the State that are delivering no OB services.

I have had in the past 2 weeks, two young ladies with no prenatal care from one of these counties presented at Greene County Hospital in active labor. They come in in active labor, so you cannot send them anywhere, you have to deliver them. One gave birth to an infant that weighed 5 pounds, which is considered low birth weight. And the other one weighed 10 pounds, 13 ounces, still a problem. Both are high-risk women and high-risk babies. No one enjoys the liability associated with such patients. We do not turn people around at the door, but we are concerned how much longer can we keep our doors open for this type of situation as the malpractice and liability is so shaky with these type patients.

I work in the West Alabama area because there is a need, the people are caring and wonderful and I love the beauty of the area. However, the enormous need and the extremely low economic conditions of the area can become frustrating. There will always be a few dedicated people; but this small number will not be able to continue to carry the tremendous load.

Mr. Chairman, the following problems still remain:

(1) fewer physicians who perform deliveries;

(2) malpractice crisis continues;

(3) transportation is a problem in rural areas;

(4) teen-age pregnancy which adds to infant mortality; and

(5) the need for improved parenting skills.

With continued funding for the present programs that exist, funding for programs in nutrition and funding for health preven-

tion and promotion, we hope to see continued decrease in infant mortality in our area, State and Nation. It is my hope no baby in my service area, the State or Nation should die from preventable causes.

Thank you.

Mr. ESPY. Thank you so much for your testimony. The area of Alabama which you serve seems to be exactly like the area I serve in western Mississippi, flat and fertile and poor, very much rural with a whole lot of problems. I know exactly what you are saying.

Ms. Bentley.

[The prepared statement of Dr. Hullett appears at the conclusion of the hearing, see p. 128.]

STATEMENT OF EMILY BENTLEY, REPORTER, ALABAMA JOURNAL

Ms. BENTLEY. If there is no objection, I would like to have my written testimony entered into the record, but I would like——

Mr. ESPY. Without objection, so ordered.

Ms. BENTLEY [continuing]. To go on and make some other observations that I did not include in my written presentation.

I am a reporter and these people that you have heard before so far today have been experts to a large extent and many of them are people we used as sources for the series of articles we did, and I appreciate their help and the things they do every day in relationship to this problem.

They often see every day things that would make you cry. They made me cry. My job was to come back and put that in perspective of our larger society and what that would do to people who might come out from a suburban household and see the conditions many of these infant deaths are taking place in.

Infant mortality is a tragedy, it is a personal tragedy for families, it is a larger tragedy for our society as a whole. It affects all areas of our society, I talked to a woman who was married to a wealthy man in a north Alabama community and delivery services had stopped in their small town, so she lost her baby en route to Birmingham for delivery because there was no delivery in Cullman.

There are also women who are out in rural areas and are in abject poverty and it is a cycle of poverty that has seen generations of infant deaths and generations of poverty.

For that reason and others, infant mortality is costly as others of these witnesses have told you. An extended neonatal stay, $150,000 is not unusual.

But it is costly in other less tangible terms. Continued cycle of poverty for those children who do survive, loss of productivity as I am sure you know, a bad reputation for Alabama. There is no coincidence in the fact that Wilcox County over in west Alabama has had one of the highest mortality rates. Recently I have done some stories on public education in this State, it is no coincidence that Wilcox County has one of the biggest problems in educating their youngsters, it is all part of the same problem of poverty and a lack of education.

As these other witnesses have told you, infant mortality is preventable through greater access and availability of medical care, which I think Congress has begun addressing, increased fees for doctors, nutrition, increased ways of getting women basic nutrition and education on what their body needs and what their children need.

One of the things I think is very important in addressing unwanted children, unwanted pregnancies, particularly for teen-age mothers, I feel like getting them into a medical care system is vitally important for addressing infant mortality, but also for increasing the quality of life across the Nation.

We criticize people for having more and more children, but we give them very little to grab onto in the way of making that concrete in their lives.

In order to address infant mortality and to make these things preventable, you have got to realize that it looks like we are going to have to go after these people. You cannot just say we are going to study this, we are going to have these funds available, these programs available, we have got to go search them out is what appears to me. And after listening to some of the other testimony this morning, I think that is evident.

On that same plane, I think Alabama needs to change its attitude. Infant mortality is not new, it did not just happen last year. I think part of the reason, along with the poverty and poor education in many areas, there has been an attitude that these people are not worthy, a lot of low-income, particularly black individuals who get involved in these situations, in a cycle of poverty and their children die; part of our society has said we do not have to worry about these people, and we have not, and it has come back to haunt us and it will continue on a human emotional level and also on a financial level.

I think it is very easy to criticize low-income families' unwillingness to get medical insurance or to get medical care early. It is very easy for a middle-income individual to blame a poor person for that, and I think that attitude is much more prevalent than we care to realize. But a parallel can be drawn between those families and the way Alabama has behaved in its own policies, that being it has ignored prevention. And Alabama does not have the same out, Alabama can raise revenue, provide the funds, where a low-income family cannot. And I think Alabama must go the route of providing preventive care and transportation to get to it for its citizens.

I have great respect for the State leaders who have spoken here today, these are people who are involved in State agencies who are doing something about infant mortality. I would caution that, as at the Federal level, there is always a political aspect to public policy and that is part of it. I am not saying it is a bad thing, but funds for infants and maternal health programs can become political footballs. That has happened at times here in Alabama and I am sure it has happened at the Federal level. For that reason I think it might be a good idea—and this is not original with me—for a State trust fund for public health. If we are going to make it a priority, maybe there should be a trust fund for public health to take care of nutrition, transportation, that type thing.

At the State level, like at the Federal level, there is a conflict over just how far our government should go. I think in Alabama, for example, we provide tremendous incentives and exemptions for businesses and industry who want to come into the State and locate to provide jobs. We need to look at how we provide incentives on that front and possibly how we could provide incentives for doctors to go into counties and provide prenatal care. We need to look at our priorities.

I think Dr. Hale and others have challenged you this morning. There have to be challenges of attitude and of current public policy. That means, like at the State level, not being afraid of tax reform that goes against some of our property tax sanctity in this State. I also think that it might have something to do with a public health trust fund, setting aside money that cannot be played with, to go into public health.

At the Federal level, that means not being afraid of some of the Federal requirements for employers to provide medical care or to provide medical insurance or some incentive for companies to do that, and also for something like mandatory service for health care professionals when they get out of school. That does sound radical probably and probably to some of the people in Congress it would. But think about the weight of the issue on the public.

Thank you.

Mr. ESPY. Thank you so much. Those were some pretty good suggestions.

Ms. Sabrina Colvin, thank you for coming. We would like to turn to you at this time for any statements you would like to make, any expression you care to give us.

[The prepared statement of Ms. Bentley appears at the conclusion of the hearing, see p. 133.]

STATEMENT OF SABRINA COLVIN, MOTHER OF TWO CHILDREN, ATTALLA, AL

Ms. COLVIN. This is a first, I have never did anything like this.

Mr. ESPY. That is OK, we are all friends.

Ms. COLVIN. Well I have been pregnant three times and I have two healthy children, the first one died, I was about 6 months pregnant, he lived about an hour.

I went to a private doctor with the first baby because I did not know about the health center. I do not have insurance, I did not have insurance with any of them, and I guess I was probably 3 or 4 months pregnant when I went the first time to the doctor because I did not have insurance and doctors do not like to see you coming if you do not have insurance.

With the second baby, I went to the health center and with the third baby I tried to go to the health center, but they would not take me because I had had a Caesarean and they do not take Caesarean patients, so they sent me to a Federal Government program where they base it on your income. After that—well when I had all three babies—excuse me——

Mr. ESPY. That is OK.

Ms. COLVIN. I am a little bit nervous, I am sorry.

Mr. ESPY. Take your time.

Ms. COLVIN. I take my babies back to the health center now for their stuff and I am on the WIC Program which helps a lot. And if they are sick, I go to a private doctor, they have not been sick yet, so I haven't come to that.

That is about all I can say.

Mr. ESPY. How do you feel that the WIC Program is serving you? Do you think it is adequate or——

Ms. COLVIN. It helps a lot.

Mr. ESPY [continuing]. Is that an outreach to you?

Ms. COLVIN. Well they asked me once was I on Medicaid. I do not really know how to apply for Medicaid, they do not tell you about the programs you can get on. I just knew friends that were on WIC and that is how I got on the WIC Program. You know, I went up there and told them I would like to apply for WIC. And it does help. You stay on it with your babies for I think 6 months, until they are 6 months old.

Mr. ESPY. So as far as signing up for WIC and signing up for Medicaid, you had to approach them, there was no outreach, there was no ability—or you do not remember any attempt to come to you?

Ms. COLVIN. No, they did not come to me. I still do not know about Medicaid, I do not know if I would be eligible or not, but like I say I learned about WIC through friends. And the health center, I did not know about it until I talked to different people and they would say you can go to the health center—you have to go to them instead of them coming to you.

Mr. ESPY. If we could go back over the circumstance where you lost your first child—and again, it is not our attempt to press you for anything. In fact, we want to thank you for coming and giving us some insight into what you have gone through. I think it was very brave of you to come and give us the benefit of your experiences. Because of people like you speaking directly to us, we can change the program and make it better.

If we could go back and just recall what happened. Now you are saying that you did not go to the doctor until you were 3 months pregnant.

Ms. COLVIN. Yeah.

Mr. ESPY. Is that because——

Ms. COLVIN. I did not have insurance and to go through a private doctor—I did not know about the health center—you have to come up with cash money. And I did not have it. I was supposed to have made payments up until, you know, the time of delivery. Well I was only 6 months when I had him, so I never did make all the payments.

Mr. ESPY. Now when you finally did go to the doctor, was it a male physician?

Ms. COLVIN. Yes.

Mr. ESPY. Did he proceed—was he pretty straight in terms of sticking with you and giving you a schedule where you had to come back for follow up visits?

Ms. COLVIN. Well I had a lot of problems with that pregnancy and every time I would go in and tell them the problems I was having, they would kind of act like they did not believe what I was saying, you know. They—I guess it would have been all right if ev-

erything was normal with the pregnancy, but me having problems, they just acted like they did not believe some of the things I would tell them, and they were not really that concerned.

Mr. ESPY. Do you think the expression where they were not concerned was more out of your feeling that you were being dismissed because you had not paid or——

Ms. COLVIN. Well I do not think the doctor actually knew how the payments were going, you know, it is really up to their secretaries and everything out front, the doctor did not know how I had paid.

Mr. ESPY. Did you have problems at all with transportation in getting to the doctor?

Ms. COLVIN. Well I would if I did not have family that took care of me, I guess I would have problems getting there.

Mr. ESPY. So your family took you there?

Ms. COLVIN. Uh-huh.

Mr. ESPY. If there was one thing that you could tell your Congressman and another one from a neighboring State with many women in similar circumstances—you have an opportunity now to tell us anything on your mind insofar as what we have been doing wrong, anything that needs to be improved.

Ms. COLVIN. Well like the programs, you do not know about them, you know. Like if there are certain programs that would help you, how do you find out about them. You know, unless you ask, they do not just volunteer the information. A lot of my friends—you know, you just have to find out yourself, they do not come and tell you about what programs you can qualify for.

Mr. ESPY. You have experienced one pregnancy under the care of a private doctor and another, of course, under the care of a clinic. How would you compare the services that you received from the clinic and from the private doctor?

Ms. COLVIN. Well I like the health center, they treated you a lot better really than the private doctor. They seemed more concerned, you know, I like the way they treat you when you go there. They really are—they seem more concerned about what is happening to you and your baby than the private doctor. That is just my personal experience though.

Mr. ESPY. Sure. How did you find out about the clinic?

Ms. COLVIN. Friends. I knew a girl that had went through there and she told me about it, so I went up there.

Mr. ESPY. You say now you still do not have health insurance even at this point.

Ms. COLVIN. No.

Mr. ESPY. I guess I am dominating the questions and I do not want to do that. There are still some further things I want to ask, but I do appreciate your being here.

Let me turn now to Dr. Hullett, because honestly we share a common region. I have a district where 175,000 folks make about $6,000 a year, where a fifth of the housing is classified as substandard and dilapidated, where some of those homes still do not have indoor plumbing in 1988 in America.

Dr. HULLETT. Ours is the same way.

Mr. ESPY. Where some of the folks living there in my district, about 45 percent over 21 do not have a high school diploma and 35

percent, when they attempt to enter the military they fail to get in because of past experiences in our educational system. This tremendous problem with low-birth-weight babies and infant mortality, we see it every day, it is just a matter of life and it is really tough to try to grapple with all of that.

You are on the front line like some of the other members of previous panels that we talked with and you are grappling with these kind of issues. Within the next few weeks the Select Committee on Hunger will issue a report focusing on the issues perceived by State WIC directors to be the major barriers to participation in the WIC Program. And I was interested in the cultural and behavioral barriers discussed, particularly as they pertain to the view that prenatal health care is unimportant and unnecessary.

Based on your experience in the western part of Alabama, to what extent to you find this view to be a deterrent to a pregnant woman's effort to access programs like WIC?

Dr. HULLETT. When you say unnecessary, are you saying from other scientific—or from the patient?

Mr. ESPY. From the public point of view.

Dr. HULLETT. From the public's point of view.

Mr. ESPY. The same feeling that Ms. Bentley discussed.

Dr. HULLETT. Some of the researchers will say that prenatal care really does not affect the outcome of—and in some instances things like prematurity, prenatal care may not affect that. But what we have found in our particular projects—you know, we have some research studies plus just my every day work because I do see patients every day—we feel that prenatal care does make some difference, especially as far as, in our area as I stated before, we have very few low-birth-weight babies, and we think the WIC Program, getting the women in, the women in our study group had larger babies, they had less problems with their deliveries, and they did very well.

We also feel prenatal care does other things than just the coming and measuring and talking to the—measuring the height and talking to the mother about nutritional standards. It is that contact with the mother, that support, the caring, the encouragement of that mother to take care of herself, to stop cigarette smoking. She has friends that she can come to see, the outreach workers, that emotional support is very, very important, learning about the mother. Some people have prenatal programs, the women come in but if you ask the nurse or the doctor anything about the patient, they could not tell you any more than what the height was and the fetal heart rate. And so we feel that these extra components make the difference, they help make that difference.

Mr. ESPY. And an aggressive follow up program.

Dr. HULLETT. We have a very aggressive follow up program. We use a tracking system, a computer based tracking system that was also initially part of our grant, we put all—and the interesting thing about our counties, especially Greene County where we showed the most dramatic improvement, everybody in the county is working with the program, so even the private doctors give the name of their patients, they all go into a countywide tracking system. So that doctor can find out that patient did not show up for their prenatal care or did not bring the baby in for the 2-month

immunization or well child check. And it is a combination program between private doctors, health departments and community health centers. We think this type of cooperative program can work in small towns, again with a limited amount of money. We are using an IBM PC for the tracking.

Mr. ESPY. Thank you so much.

Ben, do you have questions?

Mr. ERDREICH. Mike, I appreciate very much the testimony and especially Ms. Colvin for coming in and giving us your insights of your own experience, but all four of the panelists I thought were excellent.

And not to echo again, but just mention Dr. Hale's comments. You know we have 21st century technology, we are always talking about being able to go out into space, you would think we could apply some of this technology right here on Earth and do a better job of just what I hear from these four panelists, communication, the inability at every level, it is not just us in government, the private sector, but it is up to everyone to get out information, to get out the information on the very basic programs that we have.

I think we could get a lot of insight as to when a deed is being accomplished I think dramatically in Greene County, I congratulate you for your program and the others that are helping in that.

And Martha Jane Patton, I would say hearing about the Partners and indeed the Governor's task force, would you not like more partners to involve the entirety of our community in getting out the word of what is there, what is available so that we can indeed have all of those, such as Ms. Colvin and others, who are in need of care, in need of just basic prenatal care and are not aware of it and do not know where to go and are not being able to get information.

I do not have any direct questions. Again, I thank each of you for coming, I think the testimony was excellent.

Thank you, Mr. Chairman.

Mr. ESPY. Mr. Harris.

Mr. HARRIS. Ms. Colvin, were you receiving Aid to Dependent Children?

Ms. COLVIN. No.

Mr. HARRIS. I do not know all of the procedures, and I guess it is shocking to me to find out that we do not have a better communication system than we do for people to know just the basic things that would be available.

Dr. Hullett, I have pointed to your program with pride many times. We are very proud of what you have done and I know a lot of other people are looking to see what has been done in Greene County. Of course you represent a pretty good practice in a lot of the congressional district that I have. I have been to your office and I think it would be well for a lot of people in government to have that opportunity to go to some clinics and see first-hand. I think we might see maybe a higher priority given to problems that we have. No. 1, if we can travel all over the world trying to bring industry to our State, then I think we can travel around and try to bring doctors to areas where we certainly need medical care. It is something that is very troubling to me when I think about it because we can do better—we can do better.

Dr. HULLETT. May I address something else about the communication? One of the things maybe you all can help us with is that social services are very needed in our small towns and communities. In most places if you have like a doctor/nurse situation where there are only two people there and you have loads of patients coming in, especially prenatal patients where they kind of herd people in and herd them out and no one really to communicate with them. If she had been in a situation where there was someone who could sit down and look at each patient that came through and could give her advice on where she could go, when they found that she was having some type of financial problem, we do need doctors, but as someone else stated earlier, we need all health care personnel. We need all of the people that are part of the team.

At one time there were Federal moneys for nutritionists and social service people which are all part of the team, and now we are putting almost all the emphasis on physicians and nurses and still lacking a big portion—losing a big portion of the team. So I would like to request if possible that you all could look at the whole health team, the whole allied health services team, the people that are related to delivering the care. This is a good example of how just having a good social worker could have helped in that particular situation.

Mr. HARRIS. Well I do not mean to limit it to doctors. We could have commitments for a lot of different things. It is something that we have got to put a higher priority on, there is no question about it. And I know that it is an embarrassment and it should be to all of us, that our State has such a high mortality rate for infants.

I just want to—Ms. Bentley, I read you and your colleagues' work and I certainly found it very informative and obviously a lot of work had gone into it because your efforts were recognized, and I hope a lot of other people in this State will recognize your efforts because I think that you helped as much as anyone to really focus and zero in on the problems that this State has in this regard and I commend you for it.

That is all I have, Mr. Chairman.

Mr. ESPY. Thank you.

I have a few more questions of both Ms. Bentley and Ms. Patton. So much of what we do depends on public perception and so much of what politicians respond to has to do with public pressure and public reaction. Sometimes, you know, we hate to say that. But you both are involved in shaping public attitudes, you on the task force and you through the newspaper.

So I really want to ask again, particularly to Ms. Patton, you serve on the Governor's task force and you have had these hearings and I understand you had your first town meeting recently.

Ms. PATTON. Yes.

Mr. ESPY. What has been the public response to this? Is there now a feeling that this is a significant statewide problem—what is the public response so far?

Ms. PATTON. Well I am looking quickly to see where the first meeting was, that was October 4 in Mobile. And unfortunately I was not able to attend that one, and I am not sure what—did you go to that?

Dr. HULLETT. [Nodding head negatively.]

Ms. PATTON. OK. And Dr. Hullett is going to the next one, which is October 11 in Selma, and we will not get to Birmingham until the 20th. So I do not know what the reactions are.

Just in general, you know, I certainly agree that you can have all the expert opinions, you can have all the best information and ideas and solutions to the problem and even money to go with it, but unless you can translate that into some kind of grassroots efforts, this lady is never going to hear anything about it.

So I think not only can volunteer groups disseminate that information, but also because we are not part of a State agency, we are the only ones that can actually go and lobby with the legislature, you know, we are not hatched or anything like that. We are actually the only ones who are free to go and push for—translate from the Sabrina Colvins and bring these people to these hearings and to the legislature and also disseminate the important information back to them about what is available, and you need to write your representative about this. We absorb so much of this technical and medical information and as a lay person, I really have become educated in the process about what is the cause of infant mortality. So I think you know the press and volunteer organizations are the crucial link here in going in and translating all of this to business and industrial leaders too.

I do not know what is going on in the town meetings and what those reactions are, but if it is anything like mine personally, I am becoming educated and part of a group of volunteer grassroots efforts that are trying to let people know what is available.

Mr. ESPY. Ms. Bentley, I want to ask you, what if anything is your newspaper doing beyond publishing the series? I recognize the fact that the story was printed and it received a Pulitzer prize, and congratulations—but, as you know, all too often women in my area do not read newspapers, in this category, they do not pick up the paper we have at home and read it.

Ms. BENTLEY. They do not lobby Congress either.

Mr. ESPY. They do not lobby Congress. Newspapers can print educational supplements for free that they can return and give to the health organizations to distribute to the client community. So, I want to ask you about this perception that you mentioned.

Ms. BENTLEY. Well we did this series last fall and I have sort of—although I have done follow up articles on what the legislature has done, what the Governor has done, and what the new rates for 1987 were since that time, the actual perception that I mentioned, I had sort of—been sublimated in my consciousness until last week. I spoke to a seminar group at the Auburn University in Montgomery, and it was a small kind of optional class they had and different events they could attend for credit. Some of them were young undergraduates, some were middle-aged, some were graduate students, there was a fairly mixed group. And I had several people in there respond, you know, well what do you mean, why do they keep having these babies anyway, why do they keep getting pregnant anyway. You know, people are not being educated.

Mr. ESPY. Right.

Ms. BENTLEY. So that was very much a downer for me.

Mr. ESPY. Yes.

Ms. BENTLEY. I do think the news media can play a big role. This is something—we are always supposed to be objective. I think you cannot really be objective about infant mortality, to be fair.

Mr. ESPY. Right.

Ms. BENTLEY. But I do not know about—I do not think we have printed any other supplements for those mothers, so I think that would be a good idea. Our paper has been involved—our publisher, I should say—involved in a local group that is called Gift of Life that has been trying to get together a group of doctors and Dr. Fox and the health department has been very helpful with it as well, to provide care for indigent patients in the Montgomery metropolitan area. I think our paper contributed our initial Pulitzer prize money to that.

Mr. ESPY. That is great. Let me try to close the hearing at this point. We are due to close at 12:30 so what I would like to do is just give a brief statement of my own and turn to Congressman Harris and to your Congressman Ben Erdreich for any remarks that he would care to make.

Just let me say that I thank you all for coming. I am here for a couple of reasons; one is because of my continued commitment in this effort to alleviating this particular problem. I mentioned that the socioeconomic statistics in my area are very much the same, particularly as in west Alabama. I am involved with the Hunger Committee, the Budget Committee, and the Agriculture Committee with our nutrition programs to try to solve the problem. It is not a Mississippi problem, it is not a black problem, it is not a white problem, it is not a Democratic or Republican problem.

The other reason that I am here is because of my tremendous respect for Ben Erdreich and Claude Harris. We work together in Congress, we meet each other every Monday in Nashville on a connecting flight that we take together to Washington, and we have a chance often to talk about problems in our respective districts. It does not matter where I have to travel just to be in the midst of these gentlemen and share their knowledge. It has been really good for me.

So I want to thank you for inviting me. And I want the public to know that none of this is partisan, but we have a lot of Members in Congress now who are trying to get re-elected, they are knocking on doors. We do not have a whole lot of time and the time we do have at home, some members decide that that time would be better spent knocking on doors and phone calling and I would like the public to know, particularly here in Alabama, that you have two Members of Congress that decided not to do that, that they would spend their time on congressional duties today, and that is great and I want to applaud them for that.

Thank you for having me, I would love to come back and I am also grateful we could beat Alabama like we did last week.

Claude.

Mr. HARRIS. Thank you, Mike, for those kind words. I would be happy to go ahead and let you have my time if you would just continue with those type of follow up remarks.

I had pretty much said my closing a minute ago when I said that I thought—and I feel very strongly that Alabama can do better than what we are doing in this regard. And I hope and pray that

we will see a continued effort. It would be interesting to me and certainly something good for the State if we could involve more business communities and the private sector in this problem. I know we have had several initiatives in Congress this last time which did not pass the Congress which dealt with health policy. And it is always a push and pull as to whether it is something the Government needs to be doing or whether it is something the private sector needs to be doing and the Government stay out of it.

So I would like to certainly encourage as much as we can at the local level, the solving of the local problems, but there are also problems that do approach and are national in scope and I think that this problem that we are dealing with today is one that is a national shame. I have forgotten the stats—was it 17 out of 21—that this country—that is not a very good thing and certainly not something that we should be proud of.

I guess I will just close—I heard a story yesterday in church that made such an impression on me and I guess it is the attitude hopefully that we can take in this. It was said that back during one of Napoleon's battles, he was up on the hill looking down and he saw his army being destroyed and he called his bugle boy and said, "Sound the retreat," and the bugle boy said, "Well I do not know how to play it," because Napoleon had never had to think about retreating. And so Napoleon looked and he continued to see his army destroyed and he says, "Sound the retreat" and the bugle boy says, "I do not know how to play it." Napoleon said, "Well just do the best you can," said, "my army is being destroyed." So the bugle boy put his bugle to his lips and began to play, and he played charge and his soldiers when they heard that felt well help is on the way and they began to fight harder and they won the battle, even though help was not on the way.

So I guess I could say in closing that we need in our own way to sound whatever battle cry that we can to move forward and maybe sometimes the help that we need may not be on the way, but if we fight hard enough ourselves, we probably can work long and hard and hopefully with some solution to it.

I just want to commend all the witnesses here today. I know it is an inconvenience for a lot of you to take time out of your busy lives, but it is a problem that I certainly think is one that we should take time out to try to meet and to solve.

So, Mike, I want to thank you again because I know it was hard for you to arrange your schedule to come over here and be with us, and I know Ben appreciates it also. So with that I just want to thank you and all of the participants and the committee staff because I think it has been a good hearing for us.

Mr. ESPY. Thank you. Congressman Erdreich.

Mr. ERDREICH. Thank you. I want to thank my colleague Claude Harris and we both thank you, Mike Espy, for coming. I think those in Birmingham who have had a chance to see this young Congressman from Mississippi understand why he is looked at as one of the outstanding new Members of Congress and has a long, and I think excellent, career ahead of him, and a colleague that we all cherish being able to serve with.

It is clear to me that when we are dealing with the most vulnerable in our society, babies who come into this world, that our com-

munity and our State and our Nation can certainly do a better job. I asked the question earlier, is this a financial problem, is this a health care problem, is this a political problem. I guess I heard from the panelists, who all were excellent, that it is a combination of all those things. And something that certainly we can do better at in all of our endeavors, be they private or public, Federal and State and local, public health departments and through the variety of agencies.

So I thank all those participating and the staff for their help in putting it together, and especially again my colleague Claude Harris for coming—Claude and I, as you know, share part of Jefferson County, he has the westernmost part and then he goes all across the State, but we have a problem not in just this county but in all 67 and all 50 States.

I think what I have heard today is going to help us come up with some new approaches and I hope just a variety of togetherness that can do a job that we need to do.

Thank you again, Mike.

Mr. ESPY. With those comments, we would like to bring this hearing to a close. Let me express again our appreciation to so many of you who came this morning, and certainly to the staff members of the Select Committee on Hunger, we want to thank you for your excellent support. And I bring you greetings from the chairman, Congressman Mickey Leland from Texas. We thank the staff for coming down and preparing us and prepping us in such a splendid way.

With that we call these hearings to a close and we will leave the record open for an additional 5 days to solicit additional testimony from any of the witnesses. Thank you.

[Whereupon, at 12:28 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. BEN ERDREICH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

I WOULD FIRST LIKE TO THANK MY DISTINGUISHED COLLEAGUES, CLAUDE HARRIS FROM THE 7TH DISTRICT OF ALABAMA, AND MIKE ESPY FROM THE 2ND DISTRICT OF MISSISSIPPI, FOR COMING TO BIRMINGHAM TO PARTICIPATE IN THIS VERY IMPORTANT FIELD HEARING BY THE SELECT COMMITTEE ON HUNGER.

I WOULD ALSO LIKE TO THANK OUR DISTINGUISHED PANEL OF WITNESSES WHO HAVE COME TO PRESENT THEIR EXPERT OPINIONS AND OFFER THEIR SUGGESTIONS ON WHAT WE CAN DO TO IMPROVE INFANT SURVIVAL RATES IN OUR STATE, AND HOPEFULLY, THE NATION.

WE ARE HERE TODAY, AT ONE OF THE GREATEST MEDICAL FACILITIES IN THE WORLD, IN OUR COUNTY HEALTH DEPARTMENT, SURROUNDED BY U.A.B.'s MEDICAL CENTER, TO

DISCUSS THE HIGH HUMAN AND FINANCIAL COST OF INADEQUATE PRENATAL CARE, AND WHAT WE CAN TO TO SIGNIFCANTLY LOWER OUR STATE AND NATION'S INFANT MORTALITY RATE.

IT IS SHOCKING TO LEARN THAT A CHILD BORN IN JAPAN, FINLAND, HONG KONG, IRELAND, AUSTRALIA, CANADA, SINGAPORE, OR ANY OF TWELVE OTHER INDUSTRIALIZED NATIONS HAS A BETTER CHANCE OF SURVIVING HIS OR HER FIRST YEAR THAN DOES A CHILD BORN IN THE UNITED STATES. WORSE YET, I AM SORRY TO SAY, FIGURES FOR 1987 INDICATE THAT THE STATE OF ALABAMA IS AMONG THE TOP FIVE STATES IN THE NATION WITH AN INFANT DEATH RATE THAT IS HIGHER THAN THE NATIONAL AVERAGE.

OF THE 59,397 BIRTHS IN ALABAMA IN 1986, 11%, OR ABOUT 5,765, RECEIVED INADEQUATE PRENATAL CARE, AND OF THAT NUMBER 1,078 BIRTHS WERE TO WOMEN WHO DID NOT RECEIVE <u>ANY</u> PRENATAL CARE.

ALABAMA'S HIGH INFANT MORTALITY RATE IS DIRECTLY LINKED TO THE HIGH PERCENTAGE OF WOMEN WHO RECEIVE INADEQUATE OR NO PRENATAL CARE.

EVERY DAY MILLIONS OF DOLLARS ARE SPENT IN ALABAMA AND ACROSS THE NATION TO SAVE BABIES BORN TOO EARLY, TOO SMALL OR TOO SICK TO HAVE THE HEALTHY START THEY DESERVE IN LIFE. THOUSANDS OF INFANTS DIE AT BIRTH, AND THOSE WHO DO SURVIVE OFTEN SUFFER PERMANENT DISABILITIES.

AMERICA CURRENTLY SPENDS OVER $2 BILLION A YEAR ON HEALTH CARE FOR LOW BIRTHWEIGHT BABIES DURING THEIR FIRST YEAR OF LIFE. AND THE LIFETIME COSTS OF CARING FOR A LOW BIRTHWEIGHT INFANT CAN REACH SOME $400,000 PER CHILD. THIS COST, BY THE WAY, DOES NOT INCLUDE THE ONGOING COSTS THAT MUST BE SHOULDERED BY EVERY COMMUNITY DUE TO UNEMPLOYMENT, UNDEREMPLOYMENT OR LONG-TERM CARE FOR THE PERMANENTLY DISABLED.

PREVENTIVE STEPS, IT IS ESTIMATED, CAN SAVE $3 FOR EVER $1 SPENT. CERTAINLY, BEN FRANKLIN'S ADAGE, "AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE," SHOULD BE FOLLOWED HERE.

WE IN ALABAMA ARE MAKING GREAT STRIDES IN REDUCING THE NUMBER OF LOW BIRTHWEIGHT BABIES, AND GOVERNOR HUNT AND THE STATE LEGISLATURE HAVE TARGETED INFANT MORTALITY AS A TOP PRIORITY FOR THE STATE.

JEFFERSON COUNTY IS THE HOME OF A WORLD-CLASS MEDICAL CENTER, U.A.B. WE HAVE THE STATE'S MOST SOPHISTICATED AND ACCESSIBLE HEALTH CARE SERVICES. THE COUNTY HEALTH DEPARTMENT HAS SEVEN HEALTH CENTERS THAT PROVIDE INFORMATION AND REFERRAL SERVICES TO WOMEN NEEDING PRENATAL CARE.

THE DEPARTMENT ALSO PROVIDES PEDIATRIC CARE FOR INFANTS AND CHILDREN IN THE COMMUNITY, AND WORKS CLOSELY WITH COOPER GREEN HOSPITAL AND U.A.B.'s MEDICAL FACILITY. AND DUE TO A RECENT MEDICAID WAIVER, THE DEPARTMENT IS NOW OFFERING EXPANDED SOCIAL SUPPORT AND CASE MANAGEMENT TO THOSE MOST IN NEED.

YET SURPRISINGLY, WITH ALL THESE SERVICES AVAILABLE, JEFFERSON COUNTY'S INFANT MORTALITY RATE IS 13.5 DEATHS PER 1000 LIVE BIRTHS, HIGHER THAN THE STATE'S 12.2 DEATHS PER 1000 LIVE BIRTHS.

THAT IS WHY ALABAMA REPRESENTATIVE CLAUDE HARRIS AND I HAVE ASKED THE SELECT COMMITTEE ON HUNGER TO COME HERE TODAY TO HEAR FIRSTHAND FROM OUR PANEL OF MATERNAL AND CHILD HEALTH EXPERTS ON WHAT CAN BE DONE TO ASSURE THAT ADEQUATE PRENATAL CARE IS AFFORDABLE AND AVAILABLE TO ALL PREGNANT WOMEN. I AM HOPEFUL

THAT THIS HEARING WILL MAKE MEANINGFUL HEADWAY IN DEVELOPING NEW STRATEGIES TO ASSURE THAT OUR NATION'S YOUNGEST AND MOST VULNERABLE CITIZENS GET OFF TO A HEALTHY START.

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PREPARED STATEMENT OF HON. CLAUDE HARRIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

MR. CHAIRMAN, TODAY PRESENTS A UNIQUE OPPORTUNITY FOR THE STATE OF ALABAMA. FOR THE VERY FIRST TIME, THE SELECT COMMITTEE ON HUNGER FROM THE U.S. HOUSE OF REPRESENTATIVES HAS TRAVELLED A GREAT DISTANCE TO EXAMINE A DIFFICULT PUBLIC POLICY ISSUE, THE RATE OF INFANT MORTALITY IN ALABAMA. IN 1986 ALABAMA HAD THE UNFORTUNATE EXPERIENCE OF BEING NAMED THE STATE WITH THE HIGHEST RATE OF INFANT MORTALITY, 13.3 DEATHS PER 1000 LIVE BIRTHS. IN 1987, THE RATE DECLINED ONLY SLIGHTLY TO 12.2 DEATHS PER 1000 LIVE BIRTHS. IT IS MY HOPE THAT AFTER THIS HEARING MORE PEOPLE WILL UNDERSTAND THE IMPORTANCE OF THESE STATISTICS.

INFANT MORTALITY PRESENTS A DOUBLE-EDGED SWORD FOR ALABAMA'S ECONOMY AND FAMILIES. WITH THE LOSS OF EACH BABY, THE COMMUNITY LOSES NOT ONLY A VALUABLE INDIVIDUAL, BUT ALSO A MEMBER WHO CAN CONTRIBUTE TO THE AREA'S WEALTH. PROSPECTIVE EMPLOYERS CHOOSE COMMUNITIES WHERE LABOR IS BOTH PLENTIFUL AND HEALTHY. IF WE WANT TO PROVIDE JOBS FOR OUR UNEMPLOYED, WE NEED TO ASSURE EMPLOYERS THAT OUR COMMUNITIES OFFER A QUALITY OF LIFE, INCLUDING HEALTH CARE, SECOND TO NONE.

THE TRAGEDY OF THIS SITUATION IS THAT ADEQUATE PREVENTIVE EFFORTS COULD GREATLY REDUCE THIS UNNECESSARY LOSS OF LIFE. IN THE AUGUST 1988 REPORT PUBLISHED BY THE NATIONAL COMMISSION TO PREVENT INFANT MORTALITY TWO GOALS ARE OUTLINED: 1) PROVIDE UNIVERSAL ACCESS TO PRENATAL CARE AND 2) INITIATE AN

EDUCATIONAL EFFORT TO MAKE THE WELL-BEING OF MOTHERS AND THEIR CHILDREN A NATIONAL PRIORITY OF ALL AMERICANS. I BELIEVE THAT THE FIRST GOAL CAN BE REALIZED BY BOTH EXPANDING HEALTH CARE INFRASTRUCTURE AS WELL AS GUARANTEEING COVERAGE FOR SERVICES RENDERED IN SUCH FACILITIES.

DEVISING STRATEGIES TO MEET THE SECOND GOAL ARE MORE DIFFICULT TO AGREE UPON. I AM CERTAIN THAT PART OF THIS EDUCATIONAL EFFORT SHOULD BE DEVOTED TO ADEQUATE NUTRITION. WE ARE FORTUNATE TODAY TO HAVE THE EXPERTISE OF MEMBERS OF THE SELECT COMMITTEE ON HUNGER, WHO ARE VERY FAMILIAR WITH THE NUTRITION NEEDS OF CHILDREN AND THEIR FAMILIES. ANOTHER SUGGESTION IS TO EXPAND THE INFANT FORMULA REBATE SYSTEM. TODAY, TWENTY FIVE STATES HAVE IMPLEMENTED THIS TYPE OF REBATE PROGRAM. I AM HOPEFUL THAT THE WITNESSES TODAY WILL OFFER VALUABLE SUGGESTIONS TO INCREASE AWARENESS OF THE ISSUE.

IN THE NEXT FEW HOURS, I, ALONG WITH MY COLLEAGUES FROM BIRMINGHAM AND MISSISSIPPI, WILL HEAR TESTIMONY PRESENTED BY WITNESSES FROM ACROSS THE STATE. THESE WITNESSES INCLUDE HEALTH CARE PROFESSIONALS, PUBLIC POLICY EXPERTS, NEWSPAPER REPORTERS, AND OTHER INTERESTED INDIVIDUALS WHO ARE DAILY COPING WITH THIS DIFFICULT SITUATION.

FINALLY, I WOULD LIKE TO TAKE THIS OPPORTUNITY TO THANK BOTH CONGRESSMAN ESPY AS WELL AS THE ENTIRE STAFF OF THE SELECT COMMITTEE ON HUNGER FOR THEIR DILIGENT EFFORTS TO SUCCESSFULLY PREPARE FOR THIS HEARING. I LOOK FORWARD TO THE OPINIONS THAT WILL BE EXPRESSED THIS MORNING.

Prepared Statement of George Perdue, Member, Alabama House of Representatives

I appreciate the opportunity afforded me today to share with you some of my concerns about infant mortality in the State of Alabama. My concerns are both personal and legislative.

I am the parent of a low birth weight, 2 lbs., 2 oz., premature daughter born in this state in 1976 in Jefferson County. She was hospitalized for the first 67 days of her life. Fortunately, due to the very excellent level of care she received in the very fine facilities in Jefferson County she was not a statistic; experienced no long term nor short term defects; is normal in every respect; a straight A sixth grade student; and slightly overweight!!

Legislatively, I became involved with efforts to combat the state's very high infant mortality rate in December, 1984, approximately one year after I was elected to the Alabama Legislature. I was appointed to the Southern Governor's Association Task Force on Infant Mortality. This Task Force was comprised of southern governors and first ladies, state legislators, mayors, public health experts, and national civic leaders who were concerned about the health of our next generation of children.

During that year, of the 58,604 Alabamians born, 815 died before their first birthday. The cold statistics work out to almost 14 deaths per 1,000 births, one of the worst in the country at that time.

In my work over the past four years with the Southern Governor's Assocciation Task Force and more recently with the Advisory Committee of the Southern Regional Task Force, as well as my work on the Governor's Task Force on Infant Mortality, a number of salient points stand out in my mind as to why our babies are dying. Most of these points were gleaned from newspaper clippings, medical journals, task force reports and discussions with many, many experts in the field of public health.

#1 A child's chance for life depends on the prenatal care the mother gets. A child's chance for health depends on the

mother's nutrition. By that measure, many of Alabama's children are penalized before they are born.

#2 Nearly one-third of all Alabama women who had babies in 1985--more than 18,000--depended on county health department clinics for all the prenatal care they received. By some estimates, more than 1,000 others had no prenatal care--the most risky pregnancy of all. In 21 of 67 counties, that care is not available.

#3 One of every three obstetricians lives in Jefferson County, while 30 counties do not have a single resident obstetrician, even for the women who can afford private care.

#4 Many of those newborns and their mothers aren't well-fed either. The nutrition programs are among the most minimally funded in the nation. Thousands of malnourished women are having malnourished children.

That begins to explain why Alabama (even in 1988) still has one of the highest infant mortality rates in the United States--which means it is one of the worst in the industrialized world.

#5 The question of prenatal care and deliveries for poor women is a loaded one, because a whole set of issues comes with it--family planning, sex education, welfare, malpractice, and finally, the unpaid bill.

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#6 Who should pay for deliveries if the woman or the family cannot pay for them: the county? the state? Who pays the bill for unplanned births when contraceptives are available at health departments? Do welfare payments encourage health or discourage responsibility?

The questions aren't new, but some doctors have begun to give a fresh answer. They are simply withdrawing their service. Some no longer accept medicaid patients at their own office. Some are fearful of malpractice suits; some are unwilling to perform deliveries for poor women, while others say the county clinics only give some women an excuse to avoid arranging private care.

#7 So the clinics are closing, leaving maternal care worse than it has been in a decade. Some of those counties are serviced by nurses or nurse practitioners, but thousands of pregnant women will have to drive further down the highway.

Legislatively, what does all this mean? First of all, it's very clear to me, that though the Health Department may have been doing what it could, it certainly has not, in the past, had much money with which to work. Support for prenatal care and family planning programs has been mostly from federal funds and they have been impacted by Gramm-Rudman budget cuts; Aid to Families with Dependent Children (AFDC) payments from Federal Block Grants in 1985 were a minimal $118 per month (16% of the Federal Poverty Level) for a family of three--lower than any other southern

state. The Women, Infants and Children (WIC) program, a federal program which provides nutrition food supplements for the poor averaged only $7.14 per week in 1985 and $7.42 per week in 1986 for each of the state's 70,000 clients.

So what has state government been doing all the while these gloomy facts have been writen about in many a newspaper across the state most notably in a "media blitz" over the past two or three years?

Prior to 1986, not much!! Although Congressman Sonny Callahan as a member of the Alabama Senate in 1980 sponsored and passed legislation to establish the Alabama Perinatal Act (80-761), no funds were appropriated. Senators Charles Martin and Hinton Mitchem amended the Act in 1981. It was not until November, 1986, that the Legislature allocated $2 million for infant mortality--$100,000 for family planning and $1.9 million for prenatal care. Only a small share of that initially was spent for prenatal services. Most of it paid for high-risk pregnancies and intensive care for premature babies and other newborns.

The state in other words was treating the symptoms of poor maternal health, not the cause, and the Legislature showed little interest in expanding--or even propping up--prenatal care.

In the 1986-87 legislative session, budget requests were made to increase the prenatal funding from $2 million to $4

million for the ensuing year. The program remained level funded during the 1987 fiscal year.

During the 1987-88 session, a push was made by several legislators to appropriate $5 million to implement a federal program known as SOBRA, which stands for Sixth Omnibus Budget Reconciliation Act. The program allows expansion of medicaid services to more pregnant women and infants, with state funds drawing almost three times their total in federal dollars.

The $5 million appropriated by the House version of the 1987-88 General Fund budget was rejected by the newly appointed Medicaid Commissioner. The Commissioner indicated that he needed no new funds for the agency. In fact, he had cut the Medicaid budgt by 5% to comply with the newly-elected Governor's directive to trim back all state agency budgets by 5% due to shortfalls projected for the 1987-88 General Fund Budget. Much confusion developed. The perinatal funds and medicaid expansion as well were in jeopardy.

First, the Senate Finance and Taxation Committee's substitute budget deleted all of the perinatal appropriation ($2 million). This bill transferred $1 million to Medicaid to be used for a federal match and the other million went to higher education. Senator John Rice amended the substitute budget to restore at least $1 million to the perinatal program. A flurry of activity took place by advocacy groups. Many contacts were

made with the Senate and House members including discussions by yours truly with the Senate Finance and Taxation Committee Chairman, the House Ways and Means Committee Chairman, and the Legislative Fiscal Officer. Perinatal and medicaid expansion needs were refocused. In summary, perinatal got back the $2 million; $1 million was allocated for medicaid expansion and a Senate Joint Resolution was passed by both houses of the Legislature expressing legislative intent on how the medicaid funds were to be spent for the SOBRA program. The Senate Joint Resolution further stipulated implementation of the SOBRA program by January 1, 1988. A battle ensued among the Governor, Medicaid Director, and several legislators regarding the implementation date as well as methods used to fund the SOBRA program. The Medicaid Commissioner favored raising the state matching funds through local effort. The Legislature favored a State General Fund appropriation. The Governor vetoed the Senate Joint Resolution prompting Senator Jim Bennett to request an Attorney General's opinion on the matter. The Attorney General's opinion sided with the Legislature, indicating essentially that legislative intent was duly expressed by both houses and that it had the force of law, Governor's veto notwithstanding. A lawsuit was subsequently filed by the Attorney General and three legislators (Messrs. Bennett, Horn and Perdue).

The lawsuit was subsequently withdrawn, allegedly because the Governor would not sign-off on monies needed to hire expert witnesses which the Attorney General had requested in preparation for the trial.

On July 1, 1988, the SOBRA program was implemented using a limited amount of appropriated funds and some private funds on a selective basis for several designated counties within the state. Testimony at this hearing by the Medicaid Commissioner details the exact level of implementation contained in the program from July 1 through September 30, 1988. The state's new fiscal year began October 1, 1988.

Current Status of Expanded Medicaid Eligibility

With time running out on the Alabama Legislature to approve a General Fund Budget for the ensuing fiscal year, less than an hour before the budget was to take effect, the Legislature gave its final approval to a budget which appropriated $6,049,592 to expand medicaid eligibility to include approximately 20,000 more women and infants throughout the state. This amount coupled with the matching federal funds allocates $22,489,144 for SOBRA. In addition to the above amount, $2,400,000 was appropriated to the Department of Public Health for SOBRA Services Program. Legislative intent was written into the Public Health section of the budget stipulating that "at least $2,000,000 shall be spent on perinatal projects."

Legislative intent was also written into the Medicaid line-item of the budget (this amendment was sponsored by yours truly, Rep. George Perdue and unanimously adopted into the budget during the Regular Session). The text of that amendment is as follows:

> "It is the intent of the Legislature that of the above appropriation, which includes $22,489,144 for SOBRA, Medicaid eligibility shall be extended to include, to the fullest extent possible, pregnant women and children up to 1 year of age who have incomes at or below 100% of the federal poverty level. It is the further intent of the Legislature that the provisions of the state's SOBRA program will include raising to a minimum of 80% of the physician's reimbursement level the reimbursement for certified midwives for deliveries under Medicaid. Also, it is the intent of the Legislature that the state's SOBRA program provide for physician reimbursement for deliveries at minimum per patient which is above the national medicaid average adjusted annually for global delivery fee and that such fee be reviewed periodically by the Alabama Medicaid Agency to

insure the rate structure provides access for prenatal care. In addition, the Legislature intends that SOBRA provisions include reimbursement to pediatricians who attend a high-risk Medicaid covered delivery. The Legislature intends that SOBRA provisions in the State allow pregnant women, who are determined to be eligible for Medicaid through SOBRA, remain eligible throughout their pregnancy, that an assets test shall not be required in making a determination of eligibility for such program, and that all providers designated under Public Law 99-509 (SOBRA) may be certifiers of presumptive eligibility for Medicaid which will insure that the eligible State population have access for said services.

The Medicaid Agency will reimburse the Department of Public Health for actual costs (in compliance with OMB Circular A.87) for services provided."

A great number of recommendations from the Governor's Task Force on Infant Mortality are included in the above legislative intent.

Testimony given here today by the Medicaid Commissioner and the State Health Officer include a number of other recommendations made and published by the Task Force.

Where Do We Go From Here?

First, a few more salient points and observations:

#1 It took three (3) legislative sessions during 1988 to pass a General Fund Budget -- a Regular Session and two special sessions.

#2 Expanding medicaid eligibility to the extent achieved required raising a number of taxes, although a number of other social services were enhanced as well.

(a) Medicaid was funded at $114,726,351; up $13,034,438 from 1987-88;

(b) Public Health was funded at $28,045,546; up $3,200,000 from 1987-88;

#3 Several county health departments raised fees to meet needs at the local level.

#4 The Legislature, Governor, State Health Officer, Medicaid Commissioner, each, set expanded medicaid eligibility as a top priority although varying and sometimes conflicting approaches were proposed during three legislative sessions.

#5 Though a record number of substitute General Fund Budgets floated through both House and Senate Finance Committees as well as floor substitutes, all versions included substantial amounts for the SOBRA program and all included identical language expressing legislative intent.

#6 PARTNERS, an advocacy group for improving women's and children's health in Alabama, played a very vital role in bringing to the attention of the Alabama Legislature and public at large the necessity to do something about Alabama's infant mortality problem. This group lobbied extensively throughout the legislative sessions from 1986-1988.

#7 The news media across the state did a superb job in helping to educate the public on the devastating infant death rate in Alabama.

#8 Tort reform legislation including the Medical Malpractice Liability Act positively impacted the environment affecting efforts to reduce infant mortality.

#9 A comprehensive case management approach has been recognized as a key component in combating the state's high infant mortality rate.

Recommendations

#1 The legislative initiatives of 1988 are only just a beginning. More funding will be needed to achieve a minimum (acceptable) level of maternal and child health care in this state.

#2 Maternal and child health care must be a priority in state government.

#3 The perinatal program, the only program currently reaching persons who are at or below 150% of the federal poverty level needs expanded funding. The Children's Defense Fund, for example, recommends eligibility at 185% of the federal poverty level.

#4 Finally, our basic problem in maternal and child health care in the country is that our health system is administered by so many agencies; it is so fragmented that there is no system left.

Instead of Congress putting a little bit here, a little bit there, Congress needs to restructure so that every citizen has access to a minimum level of health care.

REFERENCES

Why Are Our Babies Dying?, The Huntsville Times, Sunday, February 16, 1986, editorial page.

Lawmakers Lash Out At Medicaid Commissioner For Delaying SOBRA, The Alabama Journal, Wednesday, December 16, 1987, p.2.

State Health Officer Requests 10% Budget Hike, Birmingham News, Wednesday, January 6, 1988, p.10-D.

Suffer the Children, Montgomery Advertiser, Sunday, February 23, 1986, p.3-B.

Alabama Senate Substitute to House Bill 9, Second Special Session, September 30, 1988.

PREPARED STATEMENT OF CLAUDE EARL FOX, M.D., M.P.H., STATE HEALTH OFFICER, ALABAMA DEPARTMENT OF PUBLIC HEALTH

I AM PLEASED TO HAVE BEEN INVITED TO SPEAK TO YOU TODAY. I HOPE THAT I CAN CLARIFY FOR YOU THE FACTORS THAT CONTRIBUTE TO ALABAMA'S HIGH INFANT MORTALITY RATE AND THE INITIATIVES THAT THE STATE HAS UNDERTAKEN TO ALLEVIATE THIS PROBLEM.

I BECAME STATE HEALTH OFFICER IN MAY, 1986. WHILE MY PRESENT DUTIES INVOLVE DIRECTING ALL FACETS OF THE STATE HEALTH AGENCY, I HAVE HAD A CAREER-LONG INTEREST IN THE AREA OF MATERNAL AND CHILD HEALTH. I WAS BORN AND REARED IN THE MISSISSIPPI DELTA, AN AREA WHICH HAS ONE OF THE HIGHEST INFANT MORTALITY RATES IN THE NATION. GROWING UP IN AN AREA WHERE THE HEALTH NEEDS WERE ABUNDANT AND HEALTH SERVICES WERE FEW, LEFT A PERMANENT IMPRESSION ON ME AND I HAVE SPENT MY ENTIRE PROFESSIONAL LIFE IN AREAS WHICH ADDRESSED PUBLIC HEALTH CARE NEEDS. I FIRST BEGAN MY CAREER AS A LOCAL HEALTH OFFICER AND THEN A DISTRICT HEALTH OFFICER IN THE MISSISSIPPI STATE DEPARTMENT OF HEALTH. I SAW FIRST HAND THE DIFFICULTY THAT FAMILIES EXPERIENCE IN TRYING TO ACCESS CARE AND THE DEVASTATING RESULTS THAT OCCUR WHEN THE CARE IS NOT OBTAINED. IN 1980, I BECAME CHIEF OF THE BUREAU OF PERSONAL HEALTH SERVICES AND ASSUMED DIRECT LEADERSHIP OF MISSISSIPPI'S FAMILY HEALTH SERVICES PROGRAMS. I SUBSEQUENTLY BECAME DEPUTY STATE HEALTH OFFICER IN MISSISSIPPI IN 1984. DURING THIS TIME, GOVERNOR WILLIAM ALLAIN APPOINTED ME TO SERVE ON THE SOUTHERN GOVERNOR'S TASK FORCE ON INFANT MORTALITY AND I WAS ELECTED PRESIDENT OF THE NATIONAL ASSOCIATION OF MATERNAL AND CHILD HEALTH DIRECTORS. WHILE IN

MISSISSIPPI, I INSTITUTED MANY POLICIES WHICH HAD A DIRECT EFFECT ON LOWERING THE INFANT MORTALITY RATE. I FEEL THAT MY EXPERIENCES IN MISSISSIPPI HAVE ENABLED ME TO EFFECTIVELY TACKLE SIMILAR HEALTH PROBLEMS IN ALABAMA.

CONTRIBUTING FACTORS TO INFANT MORTALITY

IN 1986, WHEN I BECAME STATE HEALTH OFFICER IN ALABAMA, THIS STATE HAD THE HIGHEST INFANT MORTALITY OF ANY STATE IN THE NATION. THE PROBLEM OF INFANT MORTALITY IS MULTIFACETED AND CAN BE DESCRIBED IN TERMS WHICH ARE RELATED TO INDIVIDUALS AND THEIR FAMILIES AND IN TERMS WHICH ARE RELATIVE TO THE HEALTH CARE SYSTEM.

FACTORS RELATED TO INDIVIDUALS AND THEIR FAMILIES INCLUDE SUCH THINGS AS RACE, AGE, EDUCATION, AND SOCIOECONOMIC LEVEL.

IN RELATION TO RACE, NON-WHITE INFANT MORTALITY IN ALABAMA IS MORE THAN TWICE AS HIGH AS WHITE. THE REASONS FOR THIS DIFFERENTIAL ARE NOT CLEAR AND THUS NARROWING THE GAP BETWEEN NON-WHITE AND WHITE INFANT MORTALITY HAS BEEN DIFFICULT. IN ALABAMA APPROXIMATELY 35 PERCENT OF BIRTHS ARE TO NON-WHITE WOMEN. IN 1987, OUR NON-WHITE INFANT MORTALITY RATE WAS 18.7 PER 1,000 WHILE OUR WHITE WAS 8.7. DECREASING THIS DIFFERENCE WHILE ALSO LOWERING THE OVERALL INFANT MORTALITY IS A MAJOR GOAL FOR OUR STATE.

TEENAGE PREGNANCY IS A MAJOR CONTRIBUTOR TO ALABAMA'S INFANT MORTALITY RATE. APPROXIMATELY 17 PERCENT OF ALL BIRTHS IN THE STATE ARE TO TEENS. IN 1987, 362 OF THESE BIRTHS WERE TO THE ADOLESCENTS AT HIGHEST RISK, THOSE UNDER THE AGE OF 15. THIS IS THE HIGHEST TOTAL SINCE 1979 AND REPRESENTS A 27 PERCENT ANNUAL

INCREASE OVER 1986. OF ALL THE BIRTHS TO TEENS IN ALABAMA IN 1987, APPROXIMATELY 18.6 PERCENT WERE DUE TO REPEAT PREGNANCIES LEADING US TO CONCLUDE THAT FAMILY PLANNING SERVICES INCLUDING EDUCATION ARE INADEQUATE IN REACHING THIS LARGE SEGMENT OF THE POPULATION. IT HAS BEEN SAID THAT WHEN A TEENAGER BECOMES PREGNANT, 90 PERCENT OF HER LIFE'S SCRIPT HAS BEEN WRITTEN. TEENAGE PREGNANCY IS A TRAGEDY FOR BOTH MOTHER AND BABY AND INDEED OUR SOCIETY AS A WHOLE.

EDUCATIONAL LEVELS INFLUENCE NOT ONLY THE ABILITY TO PAY FOR HEALTH SERVICES, BUT ALSO THE KNOWLEDGE NECESSARY TO PROPERLY CARE FOR A CHILD, AND THE MOTIVATION TO EVEN SEEK HEALTH CARE. IN ALABAMA, THE MEDIAN EDUCATIONAL LEVEL IS LOWER THAN THE NATIONAL AVERAGE. THE LATEST STATISTICS AVAILABLE SHOW THAT OVER ONE-FOURTH OF OUR BIRTHS ARE TO WOMEN WITH LESS THAN A HIGH SCHOOL EDUCATION.

POVERTY PLAYS A GREAT ROLE IN PERPETUATING OUR INFANT MORTALITY PROBLEM. INTERRELATED WITH THE ABOVE FACTORS, SOCIOECONOMIC STATUS HAS IN MANY AREAS DICTATED THE QUALITY, QUANTITY, AND EVEN THE EXISTENCE OF HEALTH CARE FOR MOTHERS AND INFANTS. STATISTICS FROM THE ALABAMA MEDICAID AGENCY SHOW THAT APPROXIMATELY 53 PERCENT OF THE BIRTHS IN ALABAMA ARE TO WOMEN WHO HAVE INCOMES BELOW THE FEDERAL POVERTY LEVEL.

YET KNOWING WHICH BABIES ARE AT GREATEST RISK OF DYING BEFORE THEIR FIRST BIRTHDAYS DOESN'T LEAD DIRECTLY TO IMMEDIATE IRRADICATION OF THE PROBLEM. WE MUST HAVE A FULLY FUNCTIONAL SYSTEM OF REGIONALIZED PERINATAL HEALTH CARE WHICH IS RESPONSIVE TO THE NEEDS OF THE STATE'S TOTAL MATERNAL AND INFANT POPULATION.

ALABAMA'S PERINATAL SYSTEM HAS A SEMBLANCE OF REGIONALIZATION WHICH IS STAGGERING UNDER THE WEIGHT OF FRAGMENTATION, GEOGRAPHICAL MALDISTRIBUTION OF PROVIDERS AND GROSS FINANCIAL CONSTRAINTS.

IN ALABAMA, THERE ARE AT LEAST TWO OFFICIAL STATE AGENCIES OTHER THAN THE HEALTH DEPARTMENT WHICH SERVE PREGNANT WOMEN AND CHILDREN: THE DEPARTMENT OF HUMAN RESOURCES ADMINISTERS THE AID TO DEPENDENT CHILDREN AND FOOD STAMPS PROGRAMS; THE ALABAMA MEDICAID AGENCY ADMINISTERS THE MEDICAID PROGRAM. A MYRIAD OF OTHER AGENCIES GOVERNED BY A HOST OF DIFFERENT ENTITIES SERVE THIS POPULATION. THESE ARE ALL USUALLY AT DIFFERENT LOCATIONS AND ALL HAVE UNIQUE ELIGIBILITY CRITERIA.

SOME COMPONENTS OF A REGIONALIZED SYSTEM OF CARE HAVE BEEN ESTABLISHED IN VARIOUS SITES IN ALABAMA, BUT ALL COMPONENTS ARE NOT OPERATIONAL STATEWIDE, NOR ARE THEY WELL COORDINATED. THESE COMPONENTS INCLUDE:

1. THE PROVISION OF LEVELS OF CARE GRADED FROM HIGH-QUALITY, ROUTINE CARE (INCLUDING A SUBSIDIZED SYSTEM OF PRENATAL, DELIVERY, AND NEWBORN SERVICES) TO VERY SPECIALIZED CARE;

2. ESTABLISHMENT OF LEVEL III PERINATAL SERVICES WHICH PROVIDE:

   A. OBSTETRICAL UNITS CAPABLE OF CARING FOR COMPLICATED MATERNAL-FETAL AND NEONATAL PATIENTS;

   B. TRANSPORT SYSTEMS FOR HIGH-RISK MOTHERS AND NEWBORNS;

C. CONTINUOUSLY AVAILABLE OBSTETRICAL AND NEONATAL SERVICES;

D. CONTINUING EDUCATION PROGRAMS FOR HOSPITAL STAFFS, OTHER HEALTH PROFESSIONALS, AND THE GENERAL PUBLIC.

3. SYSTEMATIC FOLLOW-UP AND CONTINUED SURVEILLANCE OF HIGH-RISK NEWBORNS AT LEAST THROUGH THE FIRST YEAR OF AGE.

IN ALABAMA, OBSTETRICAL SERVICES ARE PROVIDED BY LOCAL HEALTH DEPARTMENTS, PRIVATE OBSTETRICIANS, THREE UNIVERSITY CENTERS AND TEN PRIMARY CARE CENTERS.

BECAUSE OF A MALDISTRIBUTION OF OBSTETRICAL PROVIDERS, AND BECAUSE OF MALPRACTICE ISSUES, 42 OF THE 67 COUNTY HEALTH DEPARTMENTS OPERATE NURSING OR NURSE PRACTITIONER-ONLY PRENATAL CLINICS. NURSING OR NURSE PRACTITIONER-ONLY CLINICS ARE THOSE WHICH DO NOT HAVE A PHYSICIAN AVAILABLE AT THE HEALTH DEPARTMENT PRENATAL CLINIC. THERE ARE ALSO 28 COUNTIES WITH NO HOSPITAL DELIVERY SERVICES. ONLY BASIC PRENATAL CARE TO LOW-RISK AND SOME MEDIUM-RISK PATIENTS IS PROVIDED THROUGH HEALTH DEPARTMENT CLINICS. ALL OTHER PATIENTS ARE REFERRED TO PRIVATE OBSTETRICIANS, OBSTETRICIANS IN PRIMARY CARE CENTERS, OR HIGH-RISK CLINICS FOR CARE. HIGH-RISK PRENATAL CLINICS ARE LOCATED AT FOUR SITES IN THE STATE. ONLY THREE OF THESE, HOWEVER, ARE REGIONAL IN NATURE (NOT LIMITING SERVICES TO RESIDENTS OF THE COUNTY IN WHICH THE CLINIC IS BASED). THERE ARE ONLY TEN PRIMARY CARE CENTERS WHICH OFFER OBSTETRIC SERVICES AND REFERRALS TO SOME OF THESE CENTERS ARE VERY LIMITED. THE EASE WITH WHICH REFERRALS ARE MADE FOR PROBLEM PREGNANCIES THEN VARIES ACROSS THE STATE FROM THE SIMPLE TO THE EXTREMELY COMPLICATED.

ALL REGIONS OF THE STATE DO NOT HAVE A REGIONAL LEVEL III MEDICAL CENTER, A STANDARDIZED SYSTEM OF FOLLOW-UP OF HIGH RISK NEWBORNS, OR AN OPTIMAL TRANSPORT SYSTEM. FOR EXAMPLE, IT IS INCREASINGLY DIFFICULT FOR LOW INCOME, HIGH-RISK WOMEN TO RECEIVE APPROPRIATE CARE IN THEIR HOME REGIONS. TRANSFER/REFERRAL PATTERNS HAVE CHANGED DRAMATICALLY IN RECENT YEARS SO THAT THE MAJORITY OF HIGH-RISK CARE IS BEING PROVIDED IN TWO AREAS OF THE STATE--BIRMINGHAM AND MOBILE. A REGIONAL MEDICAL CENTER IN ONE REGION, FOR INSTANCE, REFUSES TO TRANSPORT ALL BUT THE SICKEST BABIES. THOSE BABIES ARE TRANSPORTED BY HELICOPTER. ALSO, AS THE MALPRACTICE CRISIS HAS WORSENED, LOCAL PHYSICIANS HAVE BEEN MORE AND MORE RELUCTANT TO TREAT HIGH RISK CASES.

EDUCATION FOR STAFFS WHO FUNCTION IN HOSPITALS IS ANOTHER COMPONENT OF THE PERINATAL SYSTEM WHICH IS INADEQUATE. IT IS THE REPONSIBILITY OF THE REGIONAL PERINATAL CENTERS TO MAINTAIN PROGRAMS OF PROFESSIONAL EDUCATION FOR HOSPITALS WITHIN THEIR REGIONS. SINCE EVERY PUBLIC HEALTH AREA DOES NOT HAVE A LEVEL III PERINATAL CENTER, THERE EXISTS AN URGENT NEED TO INSURE THAT ALL LEVEL I AND II HOSPITAL STAFFS RECEIVE APPROPRIATE PERINATAL EDUCATION.

ANOTHER PROBLEM THAT EXISTS IN THE PERINATAL SYSTEM IS THAT THERE ARE NO UNIFORM NEONATAL INTENSIVE CARE UNIT FOLLOW-UP CRITERIA. IN ONE AREA ONLY INFANTS OF A SPECIFIC BIRTHWEIGHT ARE FOLLOWED BY PHYSICIANS, AND IN SOME INSTANCES PHYSICIANS ARE NOT AVAILABLE FOR FOLLOW-UP OF INFANTS AT ALL. THESE GAPS RESULT IN A FRAGMENTED SYSTEM OF CARE.

WELL BABY CARE IS AVAILABLE IN ALL 67 COUNTY HEALTH

DEPARTMENTS. HOWEVER, TRUE PRIMARY CARE, INCLUDING SICK BABY CARE, IS LIMITED TO ONLY A FEW COUNTY HEALTH DEPARTMENTS.

STATE STRATEGIES TO REDUCE INFANT MORTALITY

IN RESPONSE TO THE MANY PRESSING NEEDS THREATENING THE SURVIVAL OF OUR YOUNGEST CITIZENS, ALABAMA HAS IMPLEMENTED IN THE PAST 20 MONTHS A NUMBER OF INITIATIVES WHICH HAVE POSITIVELY AFFECTED OUR INFANT DEATH RATE.

IN JULY 1987, STATE SENATORS CALLED A SPECIAL FORUM TO FOCUS ON THE ISSUE OF INFANT MORTALITY. SPEAKERS INCLUDED REPRESENTATIVES FROM THE SOUTHERN GOVERNORS' ASSOCIATION, CURRENT AND PAST PRESIDENTS OF THE ALABAMA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS (AAP), THE DIRECTOR OF THE UNIVERSITY OF ALABAMA AT BIRMINGHAM (UAB) SCHOOL OF PUBLIC HEALTH MATERNAL AND CHILD HEALTH GRADUATE PROGRAM, AND A REPRESENTATIVE FROM THE ALABAMA PERINATAL ASSOCIATION (APA). SEVERAL HUNDRED PEOPLE ATTENDED THIS MEETING, WHICH HAD A TREMENDOUS IMPACT ON INCREASING THE STATE LEGISLATURE'S AWARENESS OF THE PROBLEM OF INFANT MORTALITY. TWO DAYS AFTER THIS HEARING, BOTH HOUSES OF THE STATE LEGISLATURE OVERWHELMINGLY VOTED TO PASS LEGISLATION SUPPORTING THE SOBRA MEDICAID EXPANSION.

FOLLOWING THE LEGISLATIVE FORUM, TWO SPECIAL LEGISLATIVE SUBCOMMITTEES WERE FORMED. THE STATE HOUSE OF REPRESENTATIVES FORMED AN INFANT MORTALITY SUBCOMMITTEE, CHAIRED BY REPRESENTATIVE TOM BUTLER AND THE STATE SENATE FORMED A HEALTH AND ENVIRONMENT SUBCOMMITTEE, CHAIRED BY LIEUTENANT GOVERNOR JIM FOLSOM, JR., WHICH HAS PRIORITIZED INFANT MORTALITY AS ONE OF ITS MAJOR ISSUES.

GUBERNATORIAL SUPPORT FOR THE ISSUE OF INFANT MORTALITY HAS ALSO BEEN FELT. GOVERNOR GUY HUNT HAS APPOINTED AN INFANT MORTALITY TASK FORCE COMPRISED OF 37 INDIVIDUALS REPRESENTING STATE AGENCIES, PROFESSIONAL ORGANIZATIONS, PRIVATE INDUSTRY, ETC. THE MISSION OF THE TASK FORCE IS TO BUILD UPON THE WORK OF A STATEWIDE INFANT MORTALITY TASK FORCE WHICH I HAD PREVIOUSLY ESTABLISHED. THE GOVERNOR'S INFANT MORTALITY TASK FORCE WILL USE THE RECOMMENDATIONS SUBMITTED BY THE HEALTH DEPARTMENT'S TASK FORCE AND PUT FORTH A COMPREHENSIVE PLAN FOR RESOLUTION TO THE INFANT MORTALITY PROBLEM. ADDITIONALLY, GOVERNOR HUNT HELD AN INFANT MORTALITY INVITATIONAL CONFERENCE IN JANUARY 1988. THE CONFERENCE WAS GEARED TOWARD BUSINESS LEADERS IN THE STATE. APPROXIMATELY 200 BUSINESS LEADERS ATTENDED THIS RESOUNDINGLY SUCCESSFUL MEETING.

FURTHER LEGISLATIVE SUPPORT IN THE AREA OF MATERNAL AND INFANT HEALTH HAS ALSO BEEN EVIDENT. FISCAL YEAR 1987 WAS THE FIRST YEAR THAT THE STATE OF ALABAMA HAS EVER APPROPRIATED DOLLARS TO THE ALABAMA DEPARTMENT OF PUBLIC HEALTH (ADPH) SPECIFICALLY FOR THE MATERNAL AND CHILD HEALTH PROGRAM. ALABAMA'S NEWBORN SCREENING LAW WAS RECENTLY AMENDED TO INCLUDE SCREENING FOR SICKLE CELL DISEASE AND OTHER HEMOGLOBINOPATHIES AS A MANDATED TEST ALONG WITH TESTS FOR PHENYLKETONURIA (PKU) AND HYPOTHYROIDISM. IN SUPPORT OF OUR NEWBORN HEMOGLOBINOPATHY PROGRAM, THE STATE HEALTH DEPARTMENT WAS AWARDED A THREE-YEAR FEDERAL GRANT.

THE STATE HEALTH DEPARTMENT HAS INSTITUTED SEVERAL MEASURES TO IMPROVE ACCESS TO CARE AND TO INCREASE THE QUALITY OF THE

MATERNAL AND INFANT CARE DELIVERED IN LOCAL COUNTY HEALTH DEPARTMENTS.

DURING FISCAL YEAR 1987, THE ADPH ADOPTED A CORE SERVICES POLICY WHICH REQUIRES THAT PRENATAL AND CHILD HEALTH CARE BE AVAILABLE IN EACH COUNTY HEALTH DEPARTMENT EVERY WORKING DAY FROM 8:00 A.M. TO 5:00 P.M. UNTIL THIS POLICY WAS ISSUED, PRENATAL SERVICES WERE UNAVAILABLE IN OVER ONE-THIRD OF THE COUNTY HEALTH DEPARTMENTS. WHERE PRENATAL SERVICES WERE AVAILABLE, THE FREQUENCY WITH WHICH CLINICS WERE HELD VARIED FROM DAILY TO BI-WEEKLY. I FURTHER MANDATED THAT EACH COUNTY HEALTH DEPARTMENT SCREEN A MINIMUM OF 50 PERCENT OF THE CHILDREN ELIGIBLE FOR THE MEDICAID EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM EACH MONTH. DURING FISCAL YEAR 1986, THE HEALTH DEPARTMENT SCREENED ONLY 19 PERCENT OF THE CHILDREN ELIGIBLE. THE CURRENT SCREENING LEVEL EXCEEDS 40 PERCENT.

THE ADPH HAS INCREASED THE NUMBER OF PHYSICIANS ON STAFF AT BOTH THE STATE AND LOCAL LEVELS. CONCOMITANT WITH THIS ADDITIONAL STAFF WERE MANDATES FOR SPECIFIC PERFORMANCE CRITERIA. A MINIMUM PERCENTAGE OF TIME TO BE SPENT DOING HANDS-ON PATIENT CARE WAS SET, AND A MINIMUM DAILY CASE LOAD WAS ALSO STIPULATED. THE ADPH HAS WRITTEN NEW JOB CLASSIFICATIONS FOR PUBLIC HEALTH SOCIAL WORKERS. PRESENTLY THE STATE MERIT SYSTEM DOES NOT ALLOW SPECIFIC EMPLOYMENT OF BACHELOR'S LEVEL SOCIAL WORKERS WITH MEDICAL EXPERIENCE. THE NEW CLASSIFICATIONS WILL ALLOW THE HEALTH DEPARTMENT TO SPECIFICALLY HIRE THESE SOCIAL WORKERS WITH MEDICAL EXPERIENCE.

THE STATE BOARD OF HEALTH RECENTLY REVISED THE STATE

PERINATAL PROGRAM GUIDELINES IN ORDER TO SPECIFY THE TYPES OF PROGRAMS FOR WHICH STATE PERINATAL FUNDS COULD BE SPENT. AN INNOVATION IN THESE GUIDELINES MANDATED THE IMPLEMENTATION OF AN INFANT DEATH REVIEW PROCESS. THROUGH THESE REVIEWS, INFANT DEATHS ARE EXAMINED IN ORDER TO IDENTIFY INADEQUACIES IN THE PERINATAL SYSTEM AND DEVELOP SOLUTIONS TO THESE PROBLEMS.

ONE SUCH INADEQUACY HAS BEEN THE LACK OF CONSUMERS' AWARENESS OF THE AVAILABILITY OF PRENATAL CARE PROVIDERS. ENDEAVORING TO INCREASE CONSUMERS' AWARENESS OF LOCAL PRENATAL RESOURCES, IN JANUARY 1987, THE STORKLINE WAS DEVELOPED. THE STORKLINE IS A TOLL-FREE TELEPHONE LINE DESIGNED TO GIVE RESOURCE INFORMATION TO WOMEN IN NEED OF PRENATAL CARE AND/OR DELIVERY SERVICES. ADDITIONALLY, THE STORKLINE OFFERS INFORMATION ON A VARIETY OF SUPPORT SERVICES SUCH AS FINANCIAL ASSISTANCE PROGRAMS, FOOD STAMPS, TRANSPORTATION SERVICES, SPOUSE ABUSE SHELTERS AND LEGAL AID. TO DATE, THE STORKLINE HAS HANDLED OVER 1100 CALLS.

IN ADDITION TO THE FEDERAL HEMOGLOBINOPATHY GRANT THAT I MENTIONED EARLIER, THE ADPH WAS AWARDED SEVERAL OTHER FEDERAL AND FOUNDATION GRANTS. A FEDERAL SPRANS GRANT WAS FUNDED TO SUPPORT THE PERINATAL SYSTEM OF CARE IN A CENTRAL ALABAMA FOUR-COUNTY AREA. A GRANT FROM THE OFFICE OF ADOLESCENT PREGNANCY PREVENTION WAS RECEIVED TO SUPPORT TEENAGE PREGNANCY PREVENTION IN ANOTHER FOUR-COUNTY AREA IN SOUTH ALABAMA. ADDITIONALLY, A GRANT FROM THE APPALACIAN REGIONAL COMMISSION WAS AWARDED TO REDUCE THE INFANT MORTALITY RATE IN THIS 35-COUNTY AREA IN THE STATE. GRANTS FROM THE ROBERT WOOD JOHNSON FOUNDATION, THE MARCH

OF DIMES, AND THE ALABAMA CHILDREN'S TRUST FUND WERE ALSO AWARDED TO SUPPORT PERINATAL SERVICES IN THE STATE. THROUGH THE RECENT FEDERAL PRIMARY CARE PERINATAL INITIATIVE, EIGHT PRIMARY CARE CENTERS IN ALABAMA HAVE JUST BEEN AWARDED GRANTS WHICH WILL ALLOW THESE AGENCIES TO EXPAND THEIR PERINATAL SERVICES IN TANDEM WITH THE HEALTH DEPARTMENT'S PLANS FOR EXPANSION.

THE RECENT DEVELOPMENT OF GRASS ROOTS ADVOCACY FOR MATERNAL AND INFANT HEALTH HAS SUPPORTED THE STATE AGENCIES' EFFORTS TO IMPROVE MATERNAL AND INFANT HEALTH. PARTNERS IN ADVOCACY IS A NETWORK OF OVER 200 GROUPS AND INDIVIDUALS IN ALABAMA WHO LOBBY ON THE LEGISLATIVE LEVEL, ADVISE ON THE AGENCY LEVEL, AND STIMULATE INTEREST ON THE LOCAL LEVEL ON ISSUES PERTAINING TO MATERNAL AND CHILD HEALTH. THREE ADVOCACY GROUPS SPEARHEAD PARTNERS: THE ALABAMA FOUNDATION FOR WOMEN'S HEALTH, THE ALABAMA ADVISORY COUNCIL ON MATERNAL AND CHILD HEALTH AND THE ALABAMA PERINATAL ASSOCIATION.

EFFORTS OF PARTNERS IN ADVOCACY HAVE BEEN AUGMENTED BY THE FORMATION OF THE COMMISSION ON INFANT MORTALITY, COMPRISED OF ALABAMA PUBLIC HEALTH ASSOCIATION, ALABAMA ACADEMY OF OBSTETRICIANS AND GYNECOLOGISTS, ALABAMA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, ALABAMA PERINATAL ASSOCIATION, AND THE ALABAMA HOSPITAL ASSOCIATION. THE GROUPS HAVE CONTRIBUTED MONEY TO HIRE A LOBBYIST TO WORK FULL TIME ON PROGRAMS TO REDUCE INFANT MORTALITY, PARTICULARLY MEDICAID EXPANSION, HEALTH DEPARTMENT EXPANSION AND SUPPORT FOR THE PERINATAL SYSTEM.

IN RESPONSE TO A GROWING NEED FOR PERINATAL SERVICES IN A FOUR-COUNTY URBAN/RURAL AREA, A COMMUNITY BASED NONPROFIT

ORGANIZATION, THE GIFT OF LIFE FOUNDATION WAS FOUNDED. THROUGH THE SUPPORT OF PRIVATE CITIZENS, LOCAL HOSPITALS, AND LOCAL AND STATE GOVERNMENTS, THE FOUNDATION IS PROVIDING COMPREHENSIVE PERINATAL SERVICES TO ALL INDIGENT PREGNANT WOMEN AND THEIR BABIES IN THE FOUR-COUNTY AREA.

THE RECOGNITION OF INFANT MORTALITY BY THE LAY PUBLIC AS A MAJOR HEALTH AND SOCIAL PROBLEM IN ALABAMA HAS BEEN ACHIEVED THROUGH MASSIVE MEDIA EFFORTS. THE ADPH, THE PARTNERS IN ADVOCACY NETWORK, THE GOVERNOR'S INFANT MORTALITY TASK FORCE AND THE COMMITTEE ON INFANT MORTALITY HAVE GENERATED HUNDREDS OF NEWSPAPER ARTICLES, RADIO AND TELEVISION TALK SHOWS, TOWN MEETINGS AND PUBLIC PRESENTATIONS TO STATE AND LOCAL ORGANIZATIONS. THE CAMPAIGN HAS BEEN INTENSIVE AND RESOUNDINGLY SUCCESSFUL, PROMPTING ONE SEASONED LOBBYIST TO REMARK "NEVER HAS AN ISSUE BEEN BROUGHT BEFORE THE ALABAMA PEOPLE WITH SUCH SUCCESS IN SUCH A SHORT PERIOD OF TIME AS THAT OF INFANT MORTALITY." ONE EXAMPLE OF THE MULTITUDES OF NEWSPAPER ARTICLES IS THE ALABAMA JOURNAL'S SERIES ENTITLED, "A DEATH IN THE FAMILY." THE JOURNAL RAN THIS WEEK-LONG SERIES LAST FALL AND SUBSEQUENTLY WON THE PULITZER PRIZE FOR GENERAL JOURNALISM FOR IT.

WIC'S ROLE IN REDUCING INFANT MORTALITY

IN 1986, AN EXTENSIVE FEDERALLY FUNDED MEDICAL EVALUATION OF THE WIC PROGRAM WAS COMPLETED. THE RESULTS SHOWED UNEQUIVOCALLY THAT WIC IMPROVES THE HEALTH OF PARTICIPATING WOMEN, INFANTS, AND CHILDREN. IT HELPS INCREASE INFANTS' HEAD SIZES, REDUCE THE INCIDENCE OF LOW BIRTH WEIGHT, REDUCE ANEMIA IN CHILDREN, REDUCE LATE FETAL DEATH, AND ON AND ON.

ALABAMA'S WIC PROGRAM SERVES AS A VALUABLE SUPPORT SERVICE IN THE AREA OF MATERNAL AND INFANT HEALTH. THROUGH THE PROVISION OF SUPPLEMENTAL FOODS, THE WIC PROGRAM OFFERS TANGIBLE REWARDS FOR SEEKING HEALTH CARE. OFTEN THE WIC PROGRAM IS A PREGNANT WOMAN'S FIRST ENCOUNTER WITH A HEALTH CARE SYSTEM. THROUGH REFERRALS TO OTHER MEDICAL AND SOCIAL SERVICE PROVIDERS, WIC SERVES AS AN IMPORTANT PORTAL INTO HEALTH CARE. THE NUTRITION EDUCATION OFFERED IN THIS PROGRAM AUGMENTS THE PRENATAL EDUCATION PROVIDED THROUGH TITLE V AND STATE MCH FUNDS.

IN ALABAMA, WIC IS PROVIDED IN 110 CLINIC SITES. THE ALABAMA WIC PROGRAM SERVES APPROXIMATELY 43,036 WOMEN AND INFANTS EACH MONTH. IN AUGUST 1988, THE ALABAMA WIC PROGRAM INSTITUTED A COST SAVING MEASURE WHICH WILL RECOUP APPROXIMATELY $30 MILLION FOR THE PROGRAM OVER A 38 MONTH PERIOD OF TIME. THE COST CONTAINMENT MEASURE, AN INFANT FORMULA REBATE SYSTEM, HAS THE MOST FAVORABLE REBATE RATE CURRENTLY UTILIZED BY ANY STATE IN THE NATION. THE COST SAVINGS WILL ALLOW US TO SERVE 19,000 MORE PARTICIPANTS A MONTH THAN WE WOULD HAVE OTHERWISE BEEN ABLE TO SERVE.

THE NEED FOR WIC SERVICES IS SO GREAT THAT SPENDING THIS REBATE MONEY HAS POSED LITTLE PROBLEM. WE HAVE DRAMATICALLY INCREASED THE NUMBER OF WOMEN AND BABIES SERVED IN JUST THE FIRST TWO MONTHS OF THE REBATE PERIOD. COST CONTAINMENT MEASURES ALONE ARE NOT SUFFICIENT TO SERVE THE ENTIRE IN-NEED POPULATION. FUNDING INCREASES MUST ACCOMPANY THESE MEASURES IF THE MISSION OF THE WIC PROGRAM IS TO BE FULLY REALIZED.

CONCLUSION

IN CONCLUSION, I WOULD LIKE TO MAKE CLEAR THAT THE PROBLEM OF INFANT MORTALITY IS COMPLEX AND SOLUTIONS MUST BE SOUGHT AT ALL LEVELS. THIS IS NOT A PROBLEM WHOSE CAUSES AND CONSEQUENCES CAN BE PIGEON HOLED. FEDERAL, STATE, AND LOCAL GOVERNMENTS MUST ESTABLISH CLEAR POLICIES LEAVING NO DOUBT THAT HEALTH CARE FOR OUR YOUNGEST AND MOST VULNERABLE CITIZENS IS A BASIC RIGHT.

Prepared Statement of J. Michael Horsley, Commissioner, Alabama Medicaid Agency

Less than two years ago, Governor Guy Hunt came into office as Alabama's first Republican governor in more than a hundred years. During the first half of his term, Governor Hunt has given our state the kind of visionary leadership it needs to prepare for the twenty-first century. Active and involved in the everyday workings of state government, the Governor has worked to make improvements and enhancements impacting the quality of life of all Alabamians. Consistently, this Administration has demonstrated a deep concern for social issues, succeeding, in the most recent legislative session, in raising the revenue necessary for adequate funding of health and human services for the 1989 fiscal year. The problems of infant mortality and morbidity have received a high priority. The priority is evidenced by the many changes in the Medicaid program made specifically to improve health care for mothers and children.

Medicaid Expansion

One of the expansions requiring new revenue provides health care for thousands of additional mothers and children under the Sixth Omnibus Budget Reconciliation Act. Provisions of SOBRA allowing expansion of Medicaid eligibility were implemented on July 1, 1988. The action was taken specifically to impact Alabama's high infant mortality rate--12.2 neonatal deaths per 1,000 live births in 1987, down slightly from 13.3 deaths in 1986.

Our state ranks among the top five in neonatal deaths. By means of enhancements to the Medicaid program and public health services in general, Alabama can and will lose this distinction. In reducing infant mortality, the state will save money over the long term. The cost of caring for a child with serious disabilities is far more than the cost of giving the mother good prenatal care.

The Medicaid expansion implemented in July applies to pregnant women and children up to one year old in families with incomes at or below the federal poverty level--currently $9,690 a year for a family of three. In contrast, prior to the change in eligibility, mothers and children qualified for Medicaid in Alabama, with very few exceptions, only if they received Aid to Dependent Children--the maximum benefit for which is only $1,416 over a year's time for a family of three.

Women qualifying under the expansion receive pregnancy-related services, including prenatal care, delivery and postpartum care up to 60 days after the birth of the baby. Eligible children qualify for all Medicaid services, including, among many others, regular health screenings to detect and treat problems early in life. In implementing the OBRA expansion, Alabama elected to adopt the "presumptive eligibility" provisions enabling women to receive prenatal care as early as possible. In addition, there is no resource requirement for eligibility, which continues for 60 days following delivery, regardless of fluctuations in the family's income.

In the 1989 fiscal year, the Medicaid expansion in Alabama is expected to cost the state and federal governments an estimated $27 1/2 million, with the federal government supplying 73 percent of the funding. Governor Hunt requested, and the Legislature included in

the Medicaid budget approved for the year, sufficient monies to continue the expansion. In the first three months of the expansion, almost 4,000 additional pregnant women and almost 600 additional children have been served by Medicaid. Excellent participation by pregnant women is attributed to high public interest in the problem of infant mortality among all Alabamians and a successful and concerted effort, by the Medicaid Agency, to publicize the new services and eligibility requirements.

A larger increase in the number of childre: being served is expected in coming months, as babies are born to newly eligible women. On the other hand, it appears that mothers are not making Medicaid application for nearly as many children as are actually eligible. This fairly low level of participation by children is attributed to the tendency of many families not to apply for coverage unless the child is sick.

Maternity Care Waiver Program

Expansion of Medicaid under SOBRA has extended eligibility to many more pregnant women than before. Services for these women are also being improved, in a number of ways. One of the most innovative approaches involves a new maternity care waiver program initiated by Medicaid in 13 counties of the state, including some of the most populous cities as well as many rural areas.

Through this program, a single, primary provider is responsible for a comprehensive system of pregnancy-related services to Medicaid-eligible women in a specified geographical area. The provider can be almost any entity with the capability of delivering the services, whether directly or through contracts with health care

resources. For all services to the individual, from the first prenatal visit until after delivery, Medicaid pays a single fee to the primary provider.

This system involves a total and complete program of health care, with services delivered according to the health risk of the patient. Included are the significant components of outreach and case management. Through outreach, pregnant women who need services are identified and encouraged to obtain prenatal care early. Through case management, a social worker or a nurse, working with a physician, monitors the pregnant woman's care, from the first prenatal visit until after delivery, assuring that the patient receives all necessary health care as well as social services.

The maternity care waiver program was initiated September 1, 1988, in three areas of the state--Morgan and Lawrence counties, with Decatur General Hospital as the primary provider; Etowah County, where services are delivered through the Etowah Quality of Life Council, Inc.; and Montgomery, Autauga, Elmore and Lowndes counties, with the Gift of Life Foundation as the single provider. On October 1, 1988, two other areas were added: Jefferson, Blount and Shelby counties, where the Jefferson County Health Department is the provider; and Greene, Hale and Sumter counties, with West Alabama Health Services, Inc., providing the services. During the first year, an estimated 5,000 pregnant women in these areas will be served through the new program, but the actual number could be more or less, depending on how many women in the Medicaid population become pregnant and how many of those take advantage of available benefits.

The maternity care waiver program restricts Medicaid-eligible pregnant women to a single provider, thus requiring approval of a

federal freedom of choice waiver. Waivers of statewideness and comparability of services are also required. The new program will enhance services to women in the affected areas, providing coordination of service delivery through a network of care. With initiation of the program, Alabama, according to the federal Health Care Financing Administration, becomes one of only six states to offer such services to Medicaid recipients. Case management delivered through one responsible provider will greatly increase the chances of the pregnant woman's staying in the system until after delivery, thus assuring a continuum of care. After delivery, family planning will be available for women who choose this service, and each mother will be encouraged to enroll her child in a program of pediatric care.

Expansion of Medicaid through SOBRA and establishment of coordinated systems of care in specific areas are directed toward delivery of better pregnancy-related services to a larger population. As dollars are spent to deliver the best of care to mothers and children in the crucial perinatal period, many more dollars will be saved. The maternity care waiver program is expected to result in a significant savings in Medicaid costs for neonatal intensive care. In fact, a savings must be shown if Alabama is to keep the waivers approved by the federal government.

Program Enhancements

Improvements in service delivery have and will be realized through enhancements to Medicaid services directly benefiting mothers and children. In the last year, the rate paid to physicians for prenatal care and delivery was raised to $675, and a similar increase was made in the amount paid for a cesarean delivery. The raise in

rates, which are now above the national average for Medicaid, was made to keep obstetricians in the program, preventing the loss of their services to Medicaid eligibles. Along similar lines, Medicaid policy has been changed to allow payment to the pediatrician when called in to attend the delivery.

In general, the number of hospital days for which Medicaid will pay is limited to 12 a year for adults, with children qualifying for additional days under certain circumstances that are costly to the hospital. In the last few months, Medicaid policy has been changed to allow payment for additional hospital days, for maternity care only, when the mother has exhausted the usual 12-day benefit.

Over a number of months, the Medicaid Agency has worked with the Health Care Financing Administration to secure approval of an extension of hospital days for children. Hospitals would provide the state portion of the funding for the extension, which would be available only for very specialized services, such as neonatal intensive care. Although HCFA has raised questions about the funding mechanism, the latest communications with the federal agency indicate that Alabama's request may be nearing approval. The long-awaited extension of hospital days for children will make specialized care more readily available to Medicaid-eligible children. Hospitals will not suffer a financial loss when a child has to have neonatal intensive care services beyond 12 days.

Emphasis on MEDIKIDS (EPSDT)

All of these enhancements, when considered separately, appear to represent small changes. Taken together, they demonstrate a planned

and coordinated approach to effecting improvements in maternal and child health services through Medicaid.

A service receiving heavy concentration of effort is the program of Early and Periodic Screening, Diagnosis and Treatment, or EPSDT. To promote better understanding and identification, this program of regular health screening is called MediKids in Alabama. The screenings aid in the early detection and treatment of problems, thus preventing serious complications, and the need for more costly care, later.

Over the many years of its existence, the preventive program of MediKids has been underutilized, for reasons that are not altogether clear. Convinced that a reversal of that trend is needed, the Medicaid Agency has stepped up outreach efforts, with successful results. With cooperation from MediKids providers, the number of children screened has gone up significantly in the last few years, from almost 25,000 in 1986 to nearly 31,000 in 1987. When all the numbers are in for fiscal year 1988, they are expected to show that more than 40,000 children were screened.

The considerable increase in the year that just ended is attributed, in great part, to a concentrated outreach effort in 16 counties of the state. That outreach program, because of its remarkable success, will be expanded to all of Alabama's 67 counties in the near future. The outreach program involves mailings encouraging mothers to have their children screened. The outreach program targets young children who have not been screened in the last 18 months. News reports have quoted the State Health Officer as naming increased MediKids outreach as one of the reasons for the slight decline in Alabama's infant mortality rate in 1987. Further emphasis on

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MediKids, in combination with the variety of other initiatives being undertaken, is expected to help reduce infant mortality and morbidity in 1988 and beyond.

Because care in the earliest years is critical to the health of the child later, the number of screenings for which Medicaid will pay is being increased. Currently, Medicaid pays for four screenings in the first two years of life, including three screenings the first year. Effective November 1, 1988, the screening schedul recommended by the American Academy of Pediatrics will be adopted by the Medicaid program in Alabama. Medicaid will pay for six screenings the first year and three the second year. Thereafter, the Medicaid schedule will provide for one screening a year up to age six and then a screening every two years until age 21. The increase in the number of screenings has been planned for some time, pending action by the Legislature on the Medicaid budget for fiscal year 1989.

Governor's Task Force on Infant Mortality

Governor Hunt's personal interest in improving the health of Alabama's mothers and children is clear. The Governor has recommended and actively supported increases in funding for Medicaid, so that, in the 1989 fiscal year, the Agency will receive $13 million more than ever received from the State General Fund. In obtaining increases for Medicaid and other human services, the Governor had to fight a rough but successful battle that included the raising of more revenue for the General Fund. Governor Hunt has encouraged changes in Medicaid that impact infant mortality. Moreover, he has asked for and received citizen input on the problem through formation of his Task Force on Infant Mortality.

The Task Force is a 36-member group formed in 1987 to provide recommendations on actions needed to reduce infant mortality and morbidity in Alabama. The Commissioner of the Alabama Medicaid Agency is Chairman of the Task Force; the State Health Officer and the Commissioner of the Department of Human Resources are Co-Chairs. The Task Force is composed of representatives from public, private and voluntary organizations, including those with a health care or social services focus. Three legislators, representatives from religious organizations and a newspaper publisher are among Task Force members.

In submitting a preliminary report to the Governor early in 1988, the Task Force outlined a number of recommendations, many of which have been implemented. The Task Force remains very active, most recently organizing a series of nine town meetings throughout the state to receive suggestions and comments from the general public. The town meetings are being held in October and November, with a report to Governor Hunt to follow. There are no plans to dissolve the Task Force in the forseeable future; its work will continue indefinitely.

Governor's Symposium on Infant Mortality

Part of the work of the Governor's Task Force on Infant Mortality has been in the realm of public education--education in the scope of the infant mortality problem, education in the need for expanded and coordinated services to mothers and children, and education in ways to bring about desired results. Although not organized by the Task Force, a Governor's Symposium on Infant Mortality, held early in 1988, formed the basis for an educational emphasis that has not

abated. The Symposium, a half-day session of information and discussion, was directed specifically toward representatives of Alabama's business community. The aim was to give leaders in business and industry an understanding of the problem and motivation to become involved in the search for solutions.

The Symposium--sponsored by the Governor with financial and planning assistance from the March of Dimes and the Southern Governors Association--was enormously successful. The meeting attracted more than 200 invited participants. One of the most popular segments of the meeting was an audiovisual presentation on infant mortality produced especially for the Symposium by Auburn University. The presentation is being shown at the town meetings now under way.

Physician Shortage

A great deal of progress has been made in moving Alabama toward a clear and permanent solution to the serious problem of infant mortality. The problem has a high degree of public interest and understanding, thanks to the efforts of a wide variety of committed and concerned groups and individuals. Clearly, the problem has been well defined and identified; just as clearly, the state has rapidly moved beyond the issues of definition and identification and toward solutions.

Many related problems persist. A significant number of Alabama counties have no obstetricians, and many obstetricians, because of malpractice concerns, no longer deliver babies. These are issues that affect all pregnant women in Alabama, not just those who qualify for Medicaid.

It is probably unrealistic to strive for a goal of full obstetrical and delivery services in every county. However, Alabama can and should assure the availability of a high quality of prenatal care everywhere in the state, with prenatal clinics coordinating delivery services for their patients at hospitals a reasonable distance away. Such a system of service for all patients compares with the network established for Medicaid patients in maternity care waiver areas.

In 1987, at the urging of Governor Hunt, the Legislature passed sweeping tort reform legislation, so that Alabama has some of the most comprehensive tort reform laws in the nation. The effect of the legislation will not be felt for a few years, but insurance rates should stabilize or go down when cases currently in litigation are settled. As the full effect of the legislation becomes evident, Alabama should experience a lessening of the trend toward loss of delivery services. The problem is complex, and not at all unique to our state. A national focus on solutions is definitely necessary to assure the availability of good prenatal and delivery services for all women.

Looking Ahead

Governor Hunt, the Alabama Medicaid Agency, the Department of Public Health and voluntary and professional health care groups, including the Governor's Task Force on Infant Mortality, are working well together in their efforts to improve maternal and child health services for all Alabamians. By everyone concerned, the expansion of Medicaid eligibility to more pregnant women and young children is considered the most important step. A 1985 study by the Medicaid Agency indicated clearly that the infant mortality rate is lower

among Medicaid eligibles than among the general population, thus confirming that access to care improves pregnancy outcomes. Access for Medicaid eligibles has been enhanced by such changes as rate increases, and the Agency plans to monitor rates to assure their comparability with payments made by Medicaid programs in other states. With innovations such as the maternity care waiver program, which the Agency hopes to expand into more areas, the population served by Medicaid will have better, more comprehensive and coordinated services. As MediKids outreach efforts are expanded, the preventive health aspects of care for young children will receive even greater emphasis.

Many problems remain, and, although the Medicaid Agency definitely has sufficient funds to continue the eligibility expansion effected in July, fiscal constraints prevent expansion to a higher income population. More needs to be done to educate all women in the need for early and continuous prenatal care, and the Department of Public Health, in particular, is making strides in this area. The high incidence of teenage pregnancy in Alabama remains a serious concern, since teenage pregnancy and infant mortality are closely related. While emphasis on better prenatal care for teenagers will make a big difference, follow-through with access to family planning needs to be stressed for all women who choose this alternative. Programs to prevent the first pregnancy among teenagers need to be developed, although there are many different opinions, both in Alabama and elsewhere, on how to proceed.

Improvements in the Medicaid program, especially those made over the past year, should have a visible effect on infant mortality in Alabama, reducing the incidence of infant deaths and disabilities

among the low income population. During this Administration, the high priority placed on the problem of infant mortality will continue, so that further improvements in Medicaid and public health services in general can be anticipated.

Prepared Statement of Martha Jane Patton, Member, Governor's Task Force on Infant Mortality

Congressmen Erdreich, Harris, and other distinguished guests:

I am pleased to participate in this hearing as a member of Governor Hunt's Task Force on Infant Mortality. This Task Force was formed approximately a year ago, in the fall of 1987. It is chaired by State Medicaid Commissioner Michael Horsley and consists of a diverse group of individuals appointed by the Governor who have demonstrated their commitment to solving the problem of infant mortality in our state. Members of the Task Force were drawn from the Legislature, state agencies, county and city agencies and governments, physicians, nurses, insurance and business executives, and private volunteer groups. Many of the organizations represented in the make-up of the Task Force were catalysts in its formation. For example, a predecessor Task Force on Prevention and Perinatal Health, formed by Alabama's State Health Officer, Dr. Claude Earl Fox, had already concerned itself with the serious problems facing our citizens on this issue. Other efforts had been launched several years ago by a coalition of organizations who first met together to celebrate the anniversary of Title V of the Social Security Act, which legislation created block grants for maternal and child health. This coaltion, which calls itself the "Partners for Improving Women's and Children's Health in Alabama" originally consisted of three groups, the Alabama Advisory Council on Maternal and Child Health, the Alabama Perinatal Association, and the Foundation for Women's Health in Alabama. The "Partners" have since been joined by many other organizations, such as the March of Dimes, to become an effective information source and lobbying force to secure adequate funding for preventive health programs. Attached to my report today are several speeches and written communications given to or generated by the various "Partner" organizations.

With these catalyst organizations creating a solid history of concern and focus toward the issue, the Governor's Task Force has made significant accomplishments toward the goal of better health for Alabama mothers and babies. The Task Force has now met four times in Montgomery, in November, January, May and July. We have divided ourselves into four Work Groups of Education/Awareness, Service Delivery, Finance, and Research. Our accomplishments include:

(1) sharing with each other and our various represented organizations all the scientific, medical and

statistical literature we can locate on the issue of infant mortality, such as the publications of the National Commission to Prevent Infant Mortality chaired by Senator Lawton Chiles;

(2) promoting and publicizing new eligibility standards for our expanded Medicaid program available under SOBRA, through brochures, posters, and town meetings. Attached to my report today is a schedule of these meetings, which will take place over this month and next in nine different locations throughout the state;

(3) pressuring the Legislature to support full funding for prenatal and preventive health care;

(4) acting as a sounding board for controversial subjects, such as the solutions to the growing malpractice insurance crisis;

(5) monitering the progress of our state toward lowering infant mortality rates;

(6) educating each other about local programs that work; and

(7) participating in the Governor's Symposium held January 28 of this year which was directed to the role of business and industry in solving our state's problems.

The Task Force has established itself as a multidisciplinary forum imminently able to solve problems in a comprehensive way. Through this method, we intend to identify the multiple issues that affect infant mortality, such as the need for rural preventive medical care, the problems of nurses, funding for case management, malpractice insurance problems, the maldistribution of health care workers, the future role of family doctors, the obstetrician shortage, and social attitudes that may block effective solutions. We do not consider ourselves a data-generating body, in that we believe the extent of the problem and solutions are already being addressed. We will continue to invite knowledgeable persons to make presentations to us. We will conduct town meetings across the state and present the information gleaned from them to the proper governmental bodies for action.

In summary, the Task Force represents a significant step toward reducing Alabama's high infant mortality rate. Being a member of the Task Force has afforded me an opportunity to solidify and act on my own commitment, and that of the organization I represent, the Foundation for

Women's Health in Alabama, and to participate, as a health care consumer, in decisions that affect the lives of my neighbors.

Thank you, Congressmen Erdreich and Harris, for this opportunity to share my experience with you and members of the Select Committee on Hunger. Our TASK is to stop the deaths and health problems of Alabama mothers and babies. The FORCE is us.

STATE OF ALABAMA
GOVERNOR'S OFFICE
MONTGOMERY 36130

GUY HUNT
GOVERNOR

September 1988

Dear Fellow Alabamians:

During the months of October and November, the Governor's Task Force on Infant Mortality will hold town meetings in nine locations around the state. Members of the Task Force realize a practical knowledge of Alabama's infant mortality problem can be gained only at the local level.

I wholeheartedly support the plans for town meetings and look forward to being apprised of their results. Having visited many communities in all parts of the state, hearing from people whose voices do not always reach as far as the Statehouse in Montgomery, I am very much aware of the valuable contributions all citizens can make to their government. I also know how different perspectives can combine to offer solutions to problems that may seem formidable.

I encourage you to attend one of the meetings and to invite your friends and acquaintances to attend, also. While Alabama's infant mortality rate declined slightly last year, we still have a very long way to go in giving all our children the opportunity for a healthy start in life. With commitment from concerned Alabamians everywhere, I am confident we can succeed.

Offices of the March of Dimes deserve special thanks for assisting the Task Force in organizing the town meetings. If you need more information after reading the enclosed flier, please contact either the March of Dimes office serving your area or the Alabama Medicaid Agency at 277-2710 in Montgomery.

Through the process of town meetings, we hope to discover what other steps state government must take to prevent infant deaths and disabilities. At the same time, and equally or more important, we hope to encourage local projects and initiatives. Your ideas and suggestions are so important--please share them with the Governor's Task Force on Infant Mortality at one of the town meetings planned for October and November.

Sincerely,

Guy Hunt

GUY HUNT
GOVERNOR

TOWN MEETINGS

SPONSORED BY: THE GOVERNOR'S TASK FORCE ON INFANT MORTALITY

HEALTHY BABIES: EVERYBODY'S BUSINESS

All interested citizens are invited to attend a Town Meeting to offer ideas and suggestions concerning the problem of Infant Mortality in Alabama.

Joining you will be health, education, and human services professionals, as well as state and local government officials.

CITY	DATE	TIME	LOCATION
Mobile	October 4	7 p.m.	Mobile Gas Service Corporation Corporate Auditorium 2828 Dauphin Street
Selma	October 11	7 p.m.	Performing Arts Center 1000 Selma Avenue
Montgomery	October 13	7 p.m.	Robert E. Lee High School Auditorium 225 Ann Street
Tuscaloosa	October 18	7 p.m.	West Alabama District Health Department 1101 Jackson Avenue
Birmingham	October 20	7 p.m.	Dennison Auditorium Jefferson County Department of Health 1400 6th Avenue South
Anniston	October 25	7 p.m.	Anniston City Auditorium 1128 Gurnee Avenue
Florence	November 1	7 p.m.	Mitchell-Hollingsworth Annex 2 Eliza Coffee Memorial Hospital Flagg Circle
Huntsville	November 10	7 p.m.	Marriott Hotel 5 Tranquility Base
Dothan	November 17	7 p.m.	Westgate Park Gym Westgate Parkway

For more information, contact your local March of Dimes office, or the Alabama Medicaid Agency in Montgomery at 277-2710.

GSD/mv
10/7/87

ALABAMA PERINATAL ASSOCIATION
PRESENTATION BY GEORGE DILLON

I WAS INVITED TO TALK WITH YOU TODAY ABOUT INFANT MORTALITY BECAUSE OF MY ASSOCIATION AS A VOLUNTEER WITH THE MARCH OF DIMES, WHICH HAS A LONG HISTORY OF FIGHTING TO REDUCE BOTH INFANT MORTALITY AND MORBIDITY.

BUT, I ALSO HAVE A PERSONAL PERSPECTIVE ON THE ROLE OF BUSINESS IN REDUCING INFANT MORTALITY. I WAS A MEMBER OF THE BUSINESS COMMUNITY FOR 16 YEARS. FOR 10 YEARS PRIOR TO RETIREMENT, I WAS THE CHIEF EXECUTIVE OFFICER OF A FORTUNE 200 COMPANY THAT MANUFACTURED AND SOLD A DIVERSIFIED LINE OF INDUSTRIAL AND MEDICAL PRODUCTS IN THE U.S. AND ABROAD. DURING THAT PERIOD, I ALSO SERVED AS A DIRECTOR OF SEVERAL OTHER INDUSTRIAL AND FINANCIAL CORPORATIONS.

BEFORE WE FOCUS ON THE REASONS WHY BUSINESS SHOULD BE CONCERNED ABOUT INFANT MORTALITY, LET'S TAKE A FEW MINUTES TO CONSIDER THE RECORD OF THE U.S. AS MEASURED BY THE HEALTH OF ITS NEWBORN BABIES.

IT IS AN ALMOST INCREDIBLE FACT THAT WE RANK BEHIND 17 OTHER COUNTRIES IN TERMS OF THE INFANT MORTALITY RATE. JUST THINK OF IT...HERE WE ARE, A WEALTHY, PROSPEROUS NATION. WE HAVE THE GREATEST MEDICAL FACILITIES IN THE WORLD. A BABY BORN SERIOUSLY ILL IN THIS COUNTRY HAS A BETTER CHANCE OF SURVIVING THAN ANYWHERE ELSE ON EARTH BECAUSE OF OUR TECHNOLOGY. YET, OUR INFANT MORTALITY RATE IS HIGHER THAN MANY OTHER INDUSTRIALIZED COUNTRIES. IN 1986, 38,525 BABIES DIED IN THIS COUNTRY BEFORE REACHING THEIR FIRST BIRTHDAY.

WHY IS THIS HAPPENING? WHY DOES OUR GREAT NATION HAVE SUCH A SORRY RECORD? BECAUSE WE LEAD THE INDUSTRIALIZED WORLD IN THE PERCENTAGE OF LOW-BIRTHWEIGHT BABIES BORN EACH YEAR -- BABIES BORN WEIGHING LESS THAN FIVE AND ONE-HALF POUNDS.

LOW BIRTHWEIGHT BABIES ARE 20 TIMES MORE LIKELY TO DIE IN THE FIRST YEAR OF LIFE. AND THE THREE WHO SURVIVE FOR EVERY ONE WHO DIES ARE MORE LIKELY TO HAVE DISABLING CONDITIONS. TWO THIRDS OF LOW-BIRTHWEIGHT BABIES WILL REQUIRE EXTENDED AND EXPENSIVE HOSPITAL CARE DURING THEIR FIRST YEAR. MANY OF THEM ARE LIKELY TO SUFFER ONE OR MORE PHYSICAL OR MENTAL DISORDERS THAT REQUIRE EXTENSIVE TREATMENT. THIS TREATMENT IN SOME CASES WILL BE FOR A LIFETIME -- AT A STAGGERING PERSONAL AND ECONOMIC COST.

EVEN OUR SUPERB TECHNOLOGY HAS NOT BEEN ABLE TO OFFSET THE HANDICAPS OF LOW BIRTHWEIGHT. TOO MANY BABIES ARE DYING! EVEN MORE BABIES ARE BEING BORN WITH DISABILITIES, SOME OF WHICH WILL MAKE IT IMPOSSIBLE FOR THEM TO SUPPORT THEMSELVES AND LIVE INDEPENDENTLY.

AND WHAT ARE WE DOING ABOUT THESE LOST AND DAMAGED LIVES? WE ARE SPENDING MONEY -- AN ENORMOUS AMOUNT OF MONEY -- AFTER THE DAMAGE HAS BEEN DONE.

THE SOUTHERN STATES, FOR A NUMBER OF REASONS, HAVE SUFFERED MORE THAN MOST OTHERS WITH HIGH RATES OF INFANT DEATH -- NINE OF THE 10 WORST INFANT MORTALITY RATES IN THE NATION ARE IN THE SOUTH. AND IN RECENT YEARS, ALABAMA HAS BEEN AMONG THE HIGHEST -- INDEED, IN 1986, ON THE BASIS OF PROVISIONAL FIGURES, ALABAMA HAD THE HIGHEST INFANT MORTALITY RATE IN THE U.S.

ALABAMA'S RATE TRANSLATES INTO THE DEATH OF 788 BABIES LAST YEAR, A 5 PERCENT INCREASE IN THE NUMBER OF BABIES FROM 1985. THE DEATH TOLL ISN'T FALLING IN ALABAMA. IT ISN'T STAYING THE SAME. IT'S GROWING. AND, THE NUMBER OF BABIES BORN WITH DISABILITIES AND SERIOUS ILLNESSES ALSO IS GROWING.

THAT'S THE BAD NEWS. THE GOOD NEWS IS THAT THERE IS A BETTER WAY -- PREVENTIVE MATERNAL AND INFANT CARE. FEWER BABIES WILL DIE -- FEWER BABIES WILL BE BORN WITH DISABILITIES AND ILLNESS. AND IT IS FAR MORE COST EFFECTIVE TO PREVENT THESE CATASTROPHES THAN TO TRY TO AMELIORATE THEM AFTER THEY OCCUR. THE PAYBACK PERIOD IS SHORT -- COST SAVINGS START PROMPTLY AFTER THE INVESTMENT IN PREVENTIVE CARE IS MADE.

DURING THE PAST SEVERAL YEARS, THE WISDOM OF PREVENTION HAS BEGUN TO BE RECOGNIZED -- AND THE SOUTHERN STATES ARE EMERGING AS LEADERS IN IMPLEMENTING NEW PREVENTION PROGRAMS.

THE TURNING POINT CAME IN 1984 WITH THE FORMATION OF THE SOUTHERN REGIONAL TASK FORCE ON INFANT MORTALITY, UNDER THE AUSPICES OF THE SOUTHERN GOVERNORS' ASSOCIATION. THE DEDICATED AND EXPERIENCED PEOPLE ON THE TASK FORCE COMMITTED THEIR EFFORTS TO IMPROVE THE HEALTH OF PREGNANT WOMEN, INFANTS AND CHILDREN THROUGHOUT THE SOUTH. THE WORK OF THE TASK FORCE HAS BEEN FUNDED AND STRONGLY SUPPORTED BY THE MARCH OF DIMES, ALONG WITH SEVERAL OTHER FOUNDATIONS, CORPORATIONS AND THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES.

THROUGH THE EFFORTS OF THE SOUTHERN REGIONAL TASK FORCE ON INFANT MORTALITY AND INITIATIVES BY INDIVIDUAL GOVERNORS AND MEMBERS OF THE LEGISLATURES, SIGNIFICANT PROGRESS HAS BEEN MADE ON A NUMBER OF FRONTS:

- EDUCATIONAL PROGRAMS ARE RAISING THE LEVEL OF AWARENESS ABOUT INFANT MORTALITY AND LOW BIRTHWEIGHT AMONG THE PUBLIC THROUGHOUT THE SOUTH AND AMONG ELECTED OFFICIALS AT ALL LEVELS.

- THE CONCERTED EFFORTS OF THE SOUTHERN STATES HELPED BRING ABOUT A SIGNIFICANT CHANGE IN THE MEDICAID PROGRAM, KNOWN AS THE SOBRA OPTION. SOBRA PROVIDES FEDERAL SUPPORT TO STATES THAT PROVIDE HEALTH SERVICES. TO PREGNANT WOMEN AND CHILDREN UNDER THE AGE OF ONE WITHOUT REQUIRING THEM TO BE ADDED TO THE WELFARE ROLLS -- A DRAMATIC ADVANCE IN THE ABILITY OF STATES TO FUND VITAL PRENATAL AND CHILD CARE.

- IMPLEMENTATION OF THE TASK FORCE RECOMMENDATIONS IS UNDERWAY IN NINE OF THE SOUTHERN STATES. FOR EXAMPLE, MISSISSIPPI HAS LEVERAGED THE SOBRA OPTION WITH OTHER EFFORTS TO PROVIDE HEALTH CARE SERVICES. MEDICAID COVERAGE IN MISSISSIPPI IS AVAILABLE TO ALL PREGNANT WOMEN WHOSE FAMILY INCOMES ARE AS MUCH AS 100 PERCENT OF THE POVERTY LEVEL. REIMBURSABLE HOSPITAL DAYS FOR CHILDREN

HAVE BEEN INCREASED FROM 15 TO 30. PHYSICIAN'S FEES FOR DELIVERY SERVICES HAVE BEEN INCREASED. AND THE DEVELOPMENT OF A REGIONALIZED HOSPITAL NETWORK WITH SPECIALIZED TRANSPORTATION SYSTEMS HAS BEEN AUTHORIZED.

- THE CORPORATE SECTOR ALSO IS BECOMING INVOLVED IN IMPROVING THE HEALTH OF INFANTS. JUST OVER A YEAR AGO, THE SOUTHERN GOVERNORS' ASSOCIATION CREATED THE SOUTHERN CORPORATE COALITION TO IMPROVE MATERNAL AND CHILD HEALTH. ITS REPORT, ENTITLED "BOARDROOMS AND BABIES" EXAMINES WHAT BUSINESS CAN AND SHOULD DO -- A SUBJECT I'LL DISCUSS IN A FEW MINUTES.

- A 34-MEMBER ECUMENICAL COUNCIL, COMPOSED OF TWO APPOINTEES BY THE GOVERNOR OF EACH OF THE SOUTHERN STATES IS SCHEDULED TO MEET NEXT MONTH. THE COUNCIL WILL EXPLORE THE WAYS THAT RELIGIOUS GROUPS CAN WORK TO REDUCE INFANT MORTALITY AND WILL ISSUE A REPORT OF ITS RECOMMENDATIONS.

DURING ITS DELIBERATIONS, THE TASK FORCE TOOK A CAREFUL LOOK AT EXISTING PATTERNS OF CARE. IN STATE AFTER STATE, THE TASK FORCE FOUND THAT PRENATAL CARE, IMPROVED NUTRITION AND INFANT HEALTH CARE CAN HAVE A SIGNIFICANT IMPACT ON INFANT DEATH AND ILLNESS. A KENTUCKY STUDY OF WOMEN WHO DIDN'T RECEIVE PRENATAL CARE FOUND THAT THEY HAD TWICE AS MANY BABIES WHO NEEDED INTENSIVE CARE. IN VIRGINIA, WOMEN WHO DIDN'T GET PRENATAL CARE HAD A RATE OF LOW BIRTHWEIGHT THAT WAS THREE TIMES HIGHER THAN WOMEN WHO DID.

THE TASK FORCE ALSO FOUND THAT EFFORTS TO HELP BABIES BE BORN HEALTHY ARE ECONOMICALLY ADVANTAGEOUS. IN LOUISIANA, STATE AND LOCAL OFFICIALS USED SPECIAL FUNDING THROUGH THE TITLE V IMPROVED PREGNANCY OUTCOME PROGRAM TO MAKE NEW SERVICES AVAILABLE TO POOR WOMEN AND CHILDREN. THE INFANT MORTALITY RATE IN THE AREA SERVED WAS CUT BY 40 PERCENT. WHEN FLORIDA INSTITUTED A PRETERM PREVENTION PROGRAM, THE INCIDENCE OF LOW BIRTHWEIGHT BABIES WAS REDUCED BY NEARLY 12 PERCENT.

THE VALUE OF PRENATAL CARE CAN BE ASSESSED IN SEVERAL WAYS. THE FIRST IS BY COMPARING THE COST OF PROVIDING IT WITH THE COST OF <u>NOT</u> PROVIDING IT. VIRGINIA, FOR EXAMPLE, ESTIMATES THAT IT COSTS ABOUT $858,000 DOLLARS TO PROVIDE PRENATAL CARE TO 3,000 WOMEN. THE COST OF <u>NOT</u> PROVIDING THAT CARE IS NEARLY $2.6 MILLION DOLLARS -- IT COSTS THREE TIMES AS MUCH <u>NOT</u> TO PROVIDE CARE.

A CALIFORNIA STUDY COMPARING THE COSTS OF NO-CARE DELIVERIES TO PRENATAL CARE DELIVERIES SHOWED THAT PRENATAL CARE SAVED NEARLY $2,200 DOLLARS PER PATIENT.

FLORIDA HAS ESTIMATED THAT BY INVESTING IN PRENATAL AND POSTNATAL CARE, THE STATE COULD SAVE ALMOST $26 MILLION A YEAR. IN OREGON, IN MICHIGAN AND IN COLORADO, PRENATAL CARE HAS BEEN SHOWN TO BE OVERWHELMINGLY COST EFFECTIVE.

NUMEROUS OTHER STUDIES INDICATE THAT FIRST YEAR SAVINGS IN COSTS RANGE FROM $1 TO $3 DOLLARS FOR EVERY DOLLAR WE INVEST. IN THE LONG-TERM, SAVINGS CAN RANGE UP TO $10 DOLLARS FOR EVERY DOLLAR WE INVEST.

THESE RESULTS DEMONSTRATE THAT THE ECONOMIC ADVANTAGES OF PRENATAL AND INFANT HEALTH CARE ARE SO CLEAR AND SO COMPELLING THAT IT WOULD BE FINANCIALLY IRRESPONSIBLE TO IGNORE THE BENEFITS.

WHY SHOULD BUSINESS BE CONCERNED?

THE STAKE OF BUSINESS IS A VERY DIRECT ONE. THE CORPORATE COALITION, IN A REPORT EARLIER THIS YEAR, FOUND THAT CORPORATE POLICIES AND PROGRAMS CAN INFLUENCE THE HEALTH OF MOTHERS AND THEIR BABIES. AND THE HEALTH OF THOSE MOTHERS AND THEIR BABIES ULTIMATELY WILL HAVE A SIGNIFICANT IMPACT ON THE PRODUCTIVITY AND PROFITABILITY OF BUSINESS IN THE U.S.

BUSINESS, FIRST OF ALL, NEEDS AS MANY HEALTHY, BRIGHT, PRODUCTIVE PEOPLE AS IT CAN RECRUIT. THE COMBINATION OF OUR DECLINING BIRTH RATE AND THE LOSS OF INFANT LIVES AND THE HIGH INCIDENCE OF PREVENTABLE INFANT DISABILITIES MAY JEOPARDIZE THE FUTURE ABILITY OF BUSINESS TO FIND ENOUGH PRODUCTIVE WORKERS.

BUSINESS, IN FACT, IS FACING A FUTURE WITH A SEVERE LABOR SHORTAGE. BY 1990, PRIVATE SECTOR DEMAND FOR EMPLOYMENT IS EXPECTED TO AGGREGATE 157 MILLION JOBS. IF THIS IS EVEN CLOSE TO THE MARK, THERE WILL BE A SHORTAGE OF OVER 23 MILLION WORKERS ACCORDING TO A RECENT REPORT BY THE COMMITTEE FOR ECONOMIC DEVELOPMENT.

SECONDLY, THE WORKFORCE ITSELF IS CHANGING RADICALLY. TODAY, SOME 30 PERCENT OF THE U.S. WORKFORCE IS MADE UP OF WOMEN OF CHILD-BEARING AGE, AND EACH YEAR ONE MILLION BABIES ARE BORN TO THESE WOMEN. MOTHERS WITH YOUNG CHILDREN ARE THE SINGLE FASTEST GROWING SEGMENT OF OUR WORKFORCE. IN 60 PERCENT OF TWO-PARENT FAMILIES, BOTH PARENTS ARE WORKING.

YET, EMPLOYERS' HEALTH INSURANCE AND LEAVE POLICIES FREQUENTLY IGNORE THESE DEMOGRAPHIC REALITIES. CONSEQUENTLY, THE CARE REQUIRED TO PRODUCE A HEALTHY BABY MAY NOT BE AFFORDABLE TO A PERSON WITH A JOB, OR CHILDBIRTH FOR A WOMAN EMPLOYEE MAY BE SYNONYMOUS WITH LOSING HER JOB. WHEN THESE CONDITIONS EXIST, JOB PERFORMANCE SUFFERS AND ABSENTEEISM AND WORKER TURNOVER INCREASE. EVERYONE LOSES -- THE EMPLOYER -- THE EMPLOYEE -- AND THE UNBORN CHILD MAY BECOME THE BIGGEST LOSER.

BUSINESS HAS A VERY PRACTICAL REASON TO SUPPORT PREVENTION -- IT PAYS A SUBSTANTIAL PART OF THE RISING COSTS OF HI-TECH INTENSIVE CARE FOR CRITICALLY ILL INFANTS AND OF REMEDIAL AND CUSTODIAL CARE FOR DISABLED CHILDREN AND ADULTS.

LET'S LOOK AT THE INTENSIVE CARE NUMBERS. THE ANNUAL COST OF NEONATAL INTENSIVE CARE IN THE U.S. EXCEEDS $1.5 BILLION. NATIONALLY, THE COST TO TREAT A VERY SICK INFANT IN A NEONATAL INTENSIVE CARE UNIT IS BETWEEN $20,000 AND $100,000 PER INFANT. IN 1986, HERE IN ALABAMA, ABOUT 3,300 BABIES WEIGHING LESS THAN TWO AND ONE-HALF POUNDS NEEDED NEONATAL INTENSIVE CARE FOR A AVERAGE OF ALMOST TWENTY DAYS, AND AN AVERAGE BILL OF ABOUT $13,000. THE TOTAL FOR THESE BILLS WAS ALMOST $43 MILLION.

HOW DOES BUSINESS SHARE IN THESE COSTS? BECAUSE THE HOSPITAL AND DOCTOR BILLS OF PATIENTS WHO CAN'T PAY ARE SHIFTED

TO PATIENTS WHO CAN, THROUGH HIGHER CHARGES, HIGHER HEALTH INSURANCE RATES AND HIGHER TAXES. IN THE U.S. IN 1986, UNCOMPENSATED COSTS AGGREGATED A BILLION DOLLARS AND BUSINESS PAID ITS SHARE BECAUSE IT IS THE LARGEST TAXPAYER IN THE U.S. AND LARGEST PROVIDER OF HEALTH INSURANCE FOR THE NON ELDERLY. INCIDENTALLY, MATERNITY AND MATERNITY RELATED CASES MAKE UP THE LARGEST CATEGORY OF UNCOMPENSATED COSTS. IN ALABAMA IN 1985, THE STATE HOSPITAL ASSOCIATION REPORTED THAT UNCOMPENSATED COSTS TOTALED $235 MILLION, MORE THAN 25% OF WHICH RELATED TO OBSTETRICS CASES.

THE COST OF CARING FOR DISABLED CHILDREN WHO SURVIVE THE FIRST YEAR ARE EVEN MORE STAGGERING. FOR EACH OF THE 752 INFANTS WHO DIED IN ALABAMA IN 1985, THREE TIMES AS MANY WERE BORN RETARDED OR DISABLED. MANY OF THESE WILL BE DEPENDENT ON THE STATE FOR LIFE. THE COST FOR RESIDENTIAL CARE FOR ONE DISABLED CHILD IS NEARLY $38,000 A YEAR -- OR $1.9 MILLION OVER A 50 YEAR LIFETIME. IF ONLY ONE-HALF OF THESE INFANTS ARE CARED FOR BY THE STATE, THE TOTAL BILL WOULD EXCEED $40 MILLION PER YEAR. AND, OF COURSE, RESIDENTIAL CARE IS ONLY ONE OF THE SERVICES PROVIDED BY THE STATE FOR ITS HANDICAPPED CHILDREN AND ADULTS -- MANY OTHER REMEDIAL AND CUSTODIAL CARE SERVICES ARE PROVIDED AND PAID FOR OUT OF TAX REVENUES -- AND BUSINESS IS THE LARGEST TAXPAYER.

SO, IT'S IN THE SELF-INTEREST OF THE BUSINESS COMMUNITY TO TAKE AN ACTIVE ROLE IN PROMOTING PREVENTION AND THEREBY REDUCING THE NUMBER OF NEWBORNS WHO REQUIRE INTENSIVE CARE AT BIRTH AND REMEDIAL AND CUSTODIAL SERVICES IN LATER YEARS.

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WHAT CAN BUSINESS DO TO HELP?

THE MOST IMPORTANT CONTRIBUTION IT CAN MAKE IS TO PROVIDE LEADERSHIP -- TO USE ITS ORGANIZATIONAL AND MANAGEMENT SKILLS TO HELP MEDICAL PROFESSIONALS CREATE AND INSTALL SYSTEMS FOR THE DELIVERY OF THE VITAL HEALTH CARE SERVICES THROUGHOUT A STATE. BUSINESS PEOPLE CAN WORK IN THEIR OWN COMMUNITIES TO ASSURE THAT THE LOCAL COMPONENTS OF THE SYSTEM ARE IN PLACE AND FUNCTIONING EFFECTIVELY.

THERE ARE SEVERAL STEPS THAT SHOULD BE TAKEN INTERNALLY BY COMPANIES. FIRST, EACH BUSINESS SHOULD ASSESS ITS OWN HEALTH INSURANCE PLAN IN THE LIGHT OF THE NEEDS OF TODAY'S WORKFORCE. TO BE ACCEPTABLE, IT SHOULD MAKE PRENATAL CARE AFFORDABLE TO EMPLOYEES AND THEIR DEPENDENTS SO THEY WILL BE ENCOURAGED TO SEE THEIR DOCTORS EARLY AND REGULARLY AND REMAIN HEALTHY AND PRODUCTIVE THROUGHOUT THEIR PREGNANCIES.

IF BUSINESS NEEDS ANY INCENTIVE TO DO THIS, SENATORS WEICKER AND KENNEDY HAVE PROVIDED IT. THERE ARE ABOUT 28 MILLION WORKERS, OR DEPENDENTS OF WORKERS, WHO HAVE NO HEALTH INSURANCE AT ALL. THESE 28 MILLION PEOPLE AMOUNT TO 80 PERCENT OF ALL OF THE PEOPLE IN THE U.S. WHO ARE NOT COVERED BY HEALTH INSURANCE. A BILL SPONSORED BY WEICKER AND KENNEDY WOULD MANDATE HEALTH INSURANCE (INCLUDING COVERAGE FOR PRENATAL AND WELL BABY CARE) FOR ALL EMPLOYEES WORKING AT LEAST 17 AND ONE-HALF HOURS A WEEK AND THEIR DEPENDENTS. OBVIOUSLY, IF BUSINESS FAILS TO ADDRESS THIS ISSUE VOLUNTARILY, IT WILL BE CONFRONTED WITH A BUREAUCRATIC SOLUTION.

I NOTED EARLIER THAT WOMEN OF CHILDBEARING AGE MAKE UP 30% OF THE WORK FORCE. YET 60% OF THESE WOMEN ARE NOT ENTITLED TO ANY MATERNITY OR PARENTAL LEAVE. BUSINESS SHOULD ESTABLISH LEAVE

POLICIES THAT ENCOURAGE WORKERS TO RETURN AFTER A PREGNANCY -- AND THUS REDUCE TURNOVER AND THE RELATED RECRUITING AND RETRAINING COSTS.

BUSINESS ALSO SHOULD SEIZE THE OPPORTUNITY TO HELP ITS OWN EMPLOYEES BECOME EDUCATED ABOUT HEALTH CARE ISSUES. ABOUT 60% OF ALL BIRTHS ARE TO WOMEN WHO ARE WORKING DURING PREGNANCY. EACH BUSINESS THAT EMPLOYS SOME OF THESE WOMEN CAN REACH THEM WITH HEALTH EDUCATION SEMINARS AND MATERIALS PRESENTED RIGHT IN THE PLANT, OFFICE OR STORE.

THE MARCH OF DIMES HAS DEVISED SEMINARS ENTITLED, "BABIES AND YOU" ESPECIALLY RELEVANT TO PREGNANCY. THE SEMINARS ADDRESS TOPICS SUCH AS NUTRITION, GENETIC COUNSELING, THE IMPACT OF SMOKING, ALCOHOL AND DRUGS, THE NEED FOR EARLY PRENATAL CARE AND THE SPECIAL RISKS OF TEENAGE PREGNANCY. THE MARCH OF DIMES PROVIDES THE SEMINAR PLANS AND RECRUITS TRAINED PROFESSIONALS TO MAKE THE PRESENTATION.

BUSINESS HAS ANOTHER WAY TO HELP -- IT CAN RECOMMEND AND SUPPORT GOVERNMENTAL INITIATIVES, USING ITS ADVOCACY SKILLS ON BEHALF OF CRITICALLY NEEDED PROGRAMS. ALABAMA IS A GOOD EXAMPLE.

A NUMBER OF STRATEGIES FOR PREVENTION HAVE BEEN DEVELOPED AND ARE SET FORTH IN DR. FOX'S SUMMARY OF "ALABAMA'S RESCUE PLAN FOR MOTHERS AND CHILDREN." SINCE THE PUBLICATION OF THAT PLAN, THE REGIONAL PERINATAL ADVISORY COMMITTEES HAVE MADE PROPOSALS TO DR. FOX DETAILING THE NEED FOR, AND THE FUNDS REQUIRED TO IMPLEMENT, A COMPREHENSIVE PERINATAL PLAN WITHIN THE STATE. THE BUSINESS COMMUNITY SHOULD FAMILIARIZE ITSELF WITH THESE PLANS AND JOIN WITH THE MEDICAL PROFESSIONALS AND THE GOVERNOR AND LEGISLATURE TO BRING THEM TO FRUITION.

GETTING INVOLVED AS ADVOCATES FOR CAUSES THAT CONCERN AND AFFECT IT ISN'T NEW FOR BUSINESS. A RECENT COMMITTE FOR ECONOMIC DEVELOPMENT REPORT INDICATES THAT BUSINESS HAS BECOME A MAJOR PLAYER IN THE EFFORT TO IMPROVE GENERAL EDUCATION IN THE U.S. IN A DETERMINED DRIVE TO FIND QUALIFIED WORKERS, IT IS ATTACKING THE ROOT OF THE PROBLEM BY FINANCING SCHOOL BUDGET SUPPLEMENTS AND LOBBYING FOR EDUCATIONAL REFORM AND BIGGER SCHOOL BUDGETS.

BUSINESS, THROUGH THE COMMITTEE FOR ECONOMIC DEVELOPMENT, ALSO HAS URGED SUPPORT FOR PRENATAL AND POSTNATAL CARE THAT COULD SIGNIFICANTLY REDUCE THE EDUCATIONAL AND HEALTH PROBLEMS OF DISADVANTAGED CHILDREN.

THERE ARE TWO SPECIFIC OPPORTUNITIES AT HAND FOR BUSINESS TO EXERCISE LEADERSHIP ON HEALTH CARE POLICIES AND PROGRAMS. THE FIRST IS TO SUPPORT THE FUNDING OF THE SOBRA OPTION IN ALABAMA. SOBRA WOULD MAKE THE STATE ELIGIBLE TO RECEIVE ABOUT $3 FOR EVERY DOLLAR IT INVESTS IN PRENATAL CARE FOR MOTHERS AND FOR INFANTS UP TO ONE YEAR OF AGE.

ALABAMA CURRENTLY HAS THE LOWEST MEDICAID ELIGIBILITY LEVEL OF ANY STATE -- 16 PERCENT OF THE FEDERAL POVERTY LEVEL. ABOUT 10,000 BABIES A YEAR ARE ELIGIBLE FOR MEDICAID FUNDING FOR PRENATAL CARE AT THAT LEVEL. FUNDING SOBRA TO 100% OF THE FEDERAL POVERTY LEVEL WOULD MAKE ANOTHER 20,000 BABIES ELIGIBLE.

WHAT WOULD THIS MEAN? AT THE OUTSET, IT WOULD REQUIRE ADDITIONAL STATE FUNDS AND PRESUMABLY ADDITIONAL TAXES TO GAIN THE 3-1 LEVERAGE PROVIDED BY THE FEDERAL FUNDS THAT BECOME AVAILABLE. WHAT WILL BE GAINED? WITHIN THE FIRST 12 MONTHS IT WILL MEAN A SIGNIFICANT REDUCTION IN THE NUMBER OF INFANT DEATHS AND THE NUMBER OF BABIES WHO WOULD OTHERWISE BE BORN WITH DISABILITIES, THE TREATMENT OF WHICH WE HAVE SEEN IS VERY

It's worth noting, that of the 17 states within the SGA, 12 already have adopted the SOBRA Option and a majority of those have funded it all the way to 100% of the proverty level.

A second opportunity for business is to support the efforts of the Governor's Task Force on Infant Mortality. Alabama, like most states, has too many needs chasing too few dollars. Business should let the Governor, the legislature and the public know that it is prepared to do its part to achieve the benefits associated with prevention.

If the business community elects to take an active role in promoting prevention here in Alabama, it will join a distinguished partnership of dedicated volunteers and expert professionals -- the members of the organizations that sponsor this conference. They are home folks from all over Alabama. They are not outsiders or trouble makers trying to upset the system. They are not self-serving. They are not just pointing out problems -- they are offering to become part of the solutions.

Through their pioneering efforts, prevention now has a good chance to become a reality. All of us owe them a great deal and the only repayment they seek is our active support of an idea whose time has come! PREVENTION.

7/6/87

I am a nurse with the health department and a distant supporting member of the Ala. Advisory council on maternal and child health. I wish I could attend the forum on July 8. But because of distance, heavy clinic schedules and under staffing, I can not attend. I hope so much that the council - that we are successful in our attempts to show the great need for legislative action supporting the issues of prenatal and child care services in our state.

As a public health nurse I see, on a daily basis, many gaps in the present system that some people believe to be adequate. I would like to tell of one such case. A young 18 yr old black girl came to the W. I. C. clinic for service recently. She had heard about WIC progam from a friend in her neighborhood.

This prenatal had seen a local physician early in the pregnancy, but did not return, because of lack of finances. She was told she would have to pay $100 the first visit. The nurse finds it difficult to manage such a patient: no prenatal care till this

visit at 38 weeks gestation. No reimbursement for services to the doctor, and most doctors reluctant to see patients after 28 weeks, hospital requiring $750 before pre-admitting. I know that the only prenatal care this client would receive would be what I can do in such a short time, at a clinic not staffed, not equipped, + untrained to handle such a person.

This client was referred immediately to the dept. of human resources. She was ineligible for medicaid, until she uses all her unemployment benefits of $77/wk. At 38 weeks, this prenatal needs the medicaid, so she can have the best medical care available. How can a decision as this be made by a social worker at Dept of human resources, someone who is not ~~to~~ trained to make medical judgments? This social worker, no doubt, is following the financial eligibility guidelines she has been given. These type of guidelines are detrent to medical care for many many individuals who have few options. This case is only one example of the gaps in a system that is functioning to eliminate those that need the assistance and can not receive

A good deal of my time is spent as a social worker trying to find financial aide and assistance for the health dept. client. The physicians offices send the client to back to the Health dept as soon as it is determined the individual has no money for care. This clinic is a very small inadequately spaced, poorly equipted and understaffed. How can we feel comfortable with providing, or trying to provide high risk prenatal care? — 90% of those who seek care are high risk some extremely high risk. But this clinic is their only link, hope for their unborn child in some cases.

If this sounds like a plea, you are right. I plan to use every opportunity to contact by phone and letter and speak to the legislators in my area regarding issues of prenatal and child care. The prenatals I see, ask only one thing — The opportunity of life and pursuit of happiness guaranteed by the constitution of the U.S. This is their desire, This is my desire for them, and this is the desire of our health officer Claude E. Fox. I am sold.

Thank you
Diane Stuckey PHN

Alabama Conference - Remarks by Sarah C. Shuptrine

July 8, 1987

The subject of infant deaths and disabilities is not a pleasant one.

You might wonder why I would consider it a pleasure and a privilege to discuss this topic with you today. It is a pleasure because of your sincere intentions to bring about action on behalf of pregnant women and infants in Alabama; and, it is a privilege because of the opportunity to be a part of your efforts to design a better future for babies born in Alabama.

Healthy, educated children are critical to efforts to improve the quality of life for our citizens throughout the South and, thus, to greatly enhance the competitive stature of Southern states. To accomplish our health, education and economic development goals, we must start at the beginning - - we must start with placing a priority on a healthy birth for every child.

Infant mortality is the rate at which infants who are born alive are dying before the age of one year. Infant mortality is a national problem as well as a regional problem. It is unacceptable that the United States of America ranks 17th among developed nations in infant deaths. The fact remains, however, that babies born in the South have less of a chance to live to their first birthday than babies born in any other region of the United States. It is the South that must take immediate and

decisive action to help the children of our region to have a healthy beginning in life.

In the summer of 1984, the Southern Governor's Association and the Southern Legislative Conference decided to launch a major effort to improve birth opportunities for babies born in the South. These two influential groups put their combined weight behind a joint task force chaired by Governor Richard W. Riley, who was then in his second term as Governor of South Carolina.

The Southern Regional Task Force on Infant Mortality filed its final of four reports in November, 1985. The final report represented a blueprint for the South in that it listed actions which all states should consider in their efforts to reduce infant mortality and morbidity.

Since the release of the report, many significant steps have been taken to place infant health needs on the priority agenda in Congress and in many states.

During the 1986 Congressional session, a major amendment to the Medicaid law was passed and funded. In supporting new appropriations, Congress recognized the long term cost savings which will result from reducing infant deaths and disabilities. Effective in April 1987, states are now allowed to provide Medicaid assistance to millions of pregnant women, infants and, children up to age five, without adding them to the welfare roles. The Medicaid amendment permits states to provide prenatal care, delivery, and post partum care for pregnant women and comprehensive health care for infants to age one in families with

incomes above a state's AFDC level, but below the federal poverty level.

The federal law provides that each state is free to choose its specific level of poverty in order to establish eligibility for AFDC and Medicaid. This is a state choice which has not worked to the benefit of children. At 100% of the federal poverty level, a family of three would have an annual income of $9,120.00. In Alabama, a family of three can have an income of no more than $1,416 a year, which is 16% of the federal poverty level. This is the lowest eligibility level of any state. It is obvious that families who have incomes between the Alabama level of poverty and the federal poverty level are not able to afford prenatal care, delivery costs or adequate health care for an infant. Necessity dictates that their hospital bills are paid and in most instances, this means that paying patients are being assessed for this cost. In the case of prenatal care, many pregnant women are going without such preventive care and this too often results in babies being born too soon or too small who then require expensive neonatal intensive care and/or lifetime care.

In the recent report of the Southern Corporate Coalition to Improve Maternal and Child Health, the Coalition supplies information on study after study which supports the need for the public and private sectors to provide comprehensive prenatal care for pregnant women. The Coalition was created in 1986 by the Southern Governor's Association and the Southern Legislative

Conference to educate business on the need to enact programs to reduce infant deaths and disabilities in Southern states.

The Coalition's report outlines the direct connection between cost shifting and the lack of adequate public and private programs for pregnant women and infants. A 1983 South Carolina study found that 43% of indigent care admissions were for women, infants and children who were not poor enough to be eligible for the state's AFDC/Medicaid Program. South Carolina has subsequently enacted a major indigent care program which raised the state's eligibility level for AFDC and Medicaid from 27% of poverty to 50% of poverty. The state also appropriated an additional $1 million so that prenatal care opportunities will be available in every county of South Carolina. Previously, 12 counties had no provision for prenatal care through the health department.

These efforts have paid off for South Carolina. This past year, the infant mortality rate continued its decline and is now at 13.2 deaths per 1,000 live births. The most dramatic result has been in the non-white births where the decline was the lowest ever recorded in South Carolina.

Alabama, like South Carolina, cannot afford to lose its young people at the current rates. All of us lose when babies die, and to know that most deaths and disabilities are preventable should spur all of us to action. We are now spending tremendous resources in rescue efforts such as neonatal intensive care where the cost for one baby can run as high as $1,000 a day;

and, in lifetime care where expenditures can and do exceed $1 million per child.

Why not invest $2,000 in a healthy birth instead of millions in high cost treatment programs?

I urge you to adopt and fund the Medicaid option which Congress has given to all states to help us provide preventive and primary care for pregnant women and infants who don't qualify for the AFDC/Medicaid programs in our states. It can be the first step in a more comprehensive approach to providing adequate health care for the children born in the South. Funding of this option will remove one obstacle for poor and low income pregnant women in your state. Other obstacles will need to be tackled as well, including inadequate provider participation, lack of health education (so that the pregnant woman is fully aware of her responsibilities in assuring a healthy birth), lack of transportation and inadequate funding of public health programs.

Alabama and other Southern States are grappling with these needs and most importantly, are taking actions to address them. Your meeting today is an important step in building support for programs which will make a difference to the outcomes for babies born in Alabama.

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NEWS RELEASE

Wednesday, May 20, 1987 - Press conference of the Alabama Chapter of the American Academy of Pediatrics at the Alabama State House, Montgomery, Alabama

Alabama pediatricians, calling attention to the state's high infant death rate, held a press conference at the Alabama State House today. The doctors, representing the Alabama Chapter of the American Academy of Pediatrics, called on the Legislature and Governor Hunt to increase state funding for health care for low income mothers and children.

Dr. Ted Williams of Dothan, Chairman of the Alabama group, stated that Alabama has the highest infant death rate of the 50 states, with 750 babies dying each year. In addition, over 2,000 babies are born in Alabama each year with a handicap or disability.

The pediatricians asserted that the high rates of infant death and disability could be reduced markedly if the state government would provide adequate funds for prenatal care, delivery services, and newborn care for low income mothers and children.

The group voiced strong support for ALABAMA'S RESCUE PLAN FOR MOTHERS AND CHILDREN, a plan prepared by the State Health Officer, Dr. Earl Fox, and the Alabama Department of Public Health. The RESCUE PLAN includes increased Medicaid funding and eligibility, plus comprehensive prenatal and child health services by the Department of Public Health and the private sector.

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The Alabama Medicaid program, which was described as seriously underfunded, could pay 72 cents out of each dollar for health care with federal funds if proper matching funds were provided by the state. For a 9 million dollar state appropriation, 20 million in federal funds could be obtained to provide the maternal, infant, and child care so desperately needed.

Dr. Williams and other pediatricians from all areas of the state emphasized the consequences now being suffered by Alabama for failure to provide for adequate care for its mothers and children: needless deaths, damaged and impaired children, and great economic loss to the state.

The cost to the state is greater than one million dollars for each child institutionalized for life due to brain injury resulting from a lack of prenatal and newborn care. Even more economic loss occurs when a disabled child is unable to become a fully functional, taxpaying citizen. The issue is clear-pay now for prevention, or pay much more later to rehabilitate and care for a damaged child.

Greater that one-third of Alabama counties now have no public prenatal care available and access to delivery services is decreasing daily. The medical liability crisis has contributed to the absence of obstetric physician services in these areas. It is hoped that tort reform will help restore physician delivery services to these areas.

The cost in human life, suffering, and economic loss to Alabama is too great. Governor Hunt and the Alabama Legislature are urged to act now to SAVE ALABAMA'S CHILDREN.

Prepared Statement of Sandral Hullett, M.D., MPH, Health Services Director, West Alabama Health Services, Inc.

Mr. Chairman, I would like to thank you for allowing me to share some of my thoughts and experiences with you on infant mortality in the West Alabama area.

Over the past decade, infant mortality rates in the United States have fallen dramatically, from 20.0 in 1970 to 10.6 in 1985. A large portion of the improvement has been due to advances in the capability to care for sick newborns, especially the premature infant, and increased emphasis being placed on early prenatal care.

Despite this overall progress, however, some population groups have participated substantially less in these improvements.

Infant and neonatal mortality rates among rural blacks remain more than twice as high as rates for whites, and the morbidity in the survivors multiplies many-fold the more easily enumerated babies who die. Inadequate prenatal care also remains higher in this population on group.

These problems which culimate in these deaths and disabled children stem in large part from the economic and social discrepancies between these rural blacks and their urban counterparts, both black and white. Lack of education, poverty, and isolation lead to inappropriate health behaviors and failure to seek medical assistance when it is needed. Often the mother's lack of knowledge and behavior patterns are passed along to the child with consequent continuation of the cycle.

West Alabama Health Services and the Health Department have assessed the needs of women and children within ten counties (Greene, Hale, Sumter, Marengo, Bibb, Pickens, Lamar, Fayette, Tuscaloosa and Choctaw) and have begun evaluating referral patterns in contiguous counties. The following information will clearly emphasize why services aimed toward reaching out to the prenatal patient and her newborn must be provided.

Infant Mortality

The WAHS service area has historically had a very high infant mortality rate. In recent years, there has been some improvement for the area, although the small population base lends itself to a spiking statistical profile.

The most dramatic improvement for 1986 (the most recent data) occurred in Greene County where the rate fell from 39.9 to 5.5, one of the five lowest in the state. WAHS feels that its maternal and early childhood health programs, centered in Greene County, have been major contributors to this decrease. These programs are being expanded to other counties.

Greene County was the only service area with a rate below that of the of the state. On the average, the rate for the service area was 18.7, 40.6% higher than Alabama's rate of 13.3. Alabama rate was the highest in the nation in 1986 and fifth in 1987.

Improvement is a slow process involving specialized care and educational programs. Rates will continue to fluctuate dramatically because of widespread poverty, poor health habits, and a small statistical base. The five-year average for the WAHS service area is 18.2 deaths per thousand as compared to the state's rate of 13.2.

INFANT MORTALITY RATES

	1980	1981	1982	1983	1984	1985	1986
National	12.5	11.7	11.2	10.9	10.6	10.6	10.4
Alabama	15.1	12.9	13.8	18.3	12.9	12.6	13.3
Choctaw	32.3	8.4	12.7	7.7	-	25.0	25.1
Greene	8.8	12.0	26.3	32.7	40.2	39.8	5.5
Hale	31.1	3.3	3.3	11.9	10.2	11.8	18.9
Marengo	17.9	15.9	12.1	15.3	28.0	15.1	21.1
Sumter	23.0	13.7	29.7	27.8	15.2	13.7	16.1
Bibb	11.2	-	26.9	20.8	23.4	21.3	4.7
Pickens	13.6	22.0	14.2	8.0	17.9	-	23.8
Lamar	12.1	8.2	23.5	15.5	-	4.3	14.6
Fayette	15.1	23.5	11.2	8.3	27.2	17.5	8.8
Tuscaloosa	12.0	11.0	11.9	12.0	14.7	9.8	18.7

Perinatal Mortality

Although the area continues to have a high rate of death to fetuses of 28 weeks or more gestation, some improvement has been made in recent years. An average of 15.8/1000 fetuses died in the service area as compared to 13.8 for the state. However, Greene County registered a rate that more than 60% below the state average. Again, WAHS feels that its programs played a major role in this improvement.

The service area average of 15.8 was the same as the rate for the previous year. However, the rate for non-whites improved by 5 full points. Despite this improvement and the increase in the rate among whites from 7.9 to 10.6, the non-white rate remains much higher at 16.8.

PERINATAL DEATH RATES

	TOTAL	WHITE	NON-WHITE
Alabama	13.8	10.8	19.3
Choctaw	16.6	9.6	21.9
Greene	5.5	-	6.5
Hale	18.7	20.3	15.7
Marengo	15.7	7.4	20.2
Sumter	19.0	15.6	19.9
Bibb	9.4	13.2	0
Pickens	32.3	29.9	34.5
Lamar	14.6	6.0	52.6
Fayette	4.4	0	19.2
Tuscaloosa	17.6	16.1	20.1

Challenge

To address infant mortality further, we must:

Improve birth weight
(1) access early to prenatal care for all pregnant patients
(2) nutrition education and nurtition assistance when needed
(3) stopping use of drugs, alcohol and tobacco during pregnancy by educationn

Prevent congenital anomalies when possible
(1) control of blood sugar in diabetic mothers
(2) proper nutrition
(3) eliminate tobacco, alcohol and drug use in pregnancy
(4) screening for diabetes in all pregnancies
(5) genetic screening and referral when indicated

Improve parenting skills (especially important for teen parents)
(1) provide instructions in safety and injury control
(2) abuse/neglect prevention and proper intervention
(3) recognition of illness in infants and importance of both access to health care and seeking prompt care when indicated

Reduce teen pregnancy rate

Improve level of knowledge about infant mortality

Strategies

West Alabama Health Services has implemented a lay home visitation program originally funded by the Ford Foundation. This program employs women from the community to encourage young women to enroll in prenatal care early, keep appoints and to give nutrition instruction before delivery of the baby. Following delivery, mother and baby are followed for two years. This form of outreach was found to be effective and cost efficient. Many states are now looking at such programs to be implemented as a state program. I would like to see monies made available to health departments, community health centers and other service related programs for outreach.

We are especially grateful for the expanded eligibility of the WIC program. We feel such program has aided in a decrease in low birth weight babies in our area. Although WIC has expanded, there is a severe shortage of nutritionists. I would encourage funding for scholarship programs. Continued support of CHC and programs to encourage programs to place physicians and other health providers in small towns and rural communities is an example of how success can and will be maintained.

If we improve nutrition and the ability to pay for service and have no providers or hospital sites in small towns, we will still have problems. A culprit in this case is malpractice insurance. Some changes must occur both state and nationwide. There are at least six counties in and surrounding our catchment area who have no delivering OB services. I have had in the past 2 weeks two young ladies with no prenatal care from one of these counties

presenting at Greene County Hospital-ER in active labor. One baby weighed 5 lbs.; and, the other weighed 6 lbs./13 oz. No one enjoys the liability associated with such patients. We do not turn people around at the door; but, we are concerned how much longer can we keep our doors open.

In conclusion, I work in the West Alabama area because there is a need, the people are caring and wonderful and I love the beauty of the area. However, the enormous need and extremely low economic conditions of the area can become frustrating. There will always be a few dedicated people; but, this small number will not be able to continue to carry the tremendous load.

Mr. Chairman, the following problems still remain:

(1) fewer physicians who perform deliveries
(2) malpractice crisis continues
(3) transportation problems
(4) teen pregnancy
(5) need for improved parenting skills

With continued funding for the present program, funding for programs in nutrition and funding for health prevention and promotion, we hope to see continued decrease in infant mortality in our area, state and nation. It is my hope no baby in my service areas, the state or nation should die from preventable causes.

Thank you for the honor of speaking.

Prepared Statement of Emily Bentley, Reporter, Alabama Journal, Montgomery, AL

Infant mortality is a tragedy for each family that experiences it. But it ultimately is a tragedy for everyone.

Alabama long has had a high infant death rate. In 1986, Alabama's rate was the highest of any state in the nation. Only pockets of poverty in the District of Columbia had a higher infant death rate.

A reporter for The Alabama Journal, I worked with three other reporters and several editors to produce a series of articles entitled "A Death in the Family, Alabama's Infant Mortality Crisis," which ran in The Journal Sept. 14-18, 1987.

We interviewed mothers with differing backgrounds. I talked to the wife of a north Alabama doctor whose child died after an hour-plus drive into Birmingham because delivery service was not available in Cullman.

I went into a home in east Alabama that housed two women and many children. There were no panes on some windows, and wind whistled through cracks in the walls.

Infant death can affect any family.

But in Alabama, and in other areas of the rural South, a cycle of poverty and poor education leaves many women without medical care or knowledge of how to take care of themselves or their children.

Infant mortality is part of a broader problem of inaccessibility of medical care.

Alabama's 1987 infant mortality rate was lower than the 1986 rate, but analysis indicates those who traditionally do not get early care still are not getting it.

Alabama and the United States are not medically backward, yet the U.S. ranks 20th among developed nations in survival rate of babies.

At the University of Alabama in Birmingham and the companion hospital, tremendous medical breakthroughs are commonplace. But in nearby neighborhoods, so are infant deaths.

We cannot say that it must be that way. Many infant deaths are preventable, according to experts. But it is clear that many cannot or do not get the preventive care they need.

In rural areas, doctors who provide prenatal care and deliver babies are rare. Many have stopped delivering in recent years because of rising malpractice insurance rates.

Poor women, including many with a partner who works but does not have medical insurance, have in the past not been eligible for Medicaid because of Alabama's low eligibility ceiling - before July of this year, $1,416 in annual income for a family of three.

So doctors often are faced with walk-in patients, ready to deliver, who have not seen a doctor during pregnancy. And many doctors have been scared out of delivery by that.

Location also is a problem. With the scarcity of prenatal and delivery care, it is difficult to get to a doctor's appointment even if you know you need to go and have the money or the insurance to pay for it.

But many disadvantaged women do not realize the importance of seeing a doctor regularly during pregnancy. They struggle to survive from day to day. And they might not know how to care for an infant at home or recognize warning signs of trouble.

Having a child seems like a natural occurrence.

For many women whose nutritional needs are not met and who may have other complications - particularly teen-agers - pregnancy without supervision can result in deformities, disease or death.

Yet public policy has left people on their own to have healthy babies.

Officials are just realizing that unhealthy babies cost the state millions in extra education, health care, institutional care and lost productivity.

Besides, it looks bad as officials try to tout Alabama as a forward-looking state.

Geography, economy and education each are part of the reason babies are not provided the early care that can increase their chances for a fair chance at life. Those blocks could be overcome if the desire and the commitment were there.

But in Alabama, that is a big "if."

Part of the reason Alabama has done little to make it easier to get medical care is that those who make policy decisions - whites in the power structure - operate on the assumption that poor blacks have gotten themselves in the dire straits they are in, they deserve it, and they merit no consideration.

The problem with that outlook is that it ruins the state's chances of significantly improving quality of life here. "Quality of life" does not refer only to the country club set.

Poor children and mothers are not campaign contributors; they do not have lobbyists or publicists. Few politicians look past popular lobby groups and political rhetoric with the vision to realize that the fate of mothers and babies is everyone's fate.

If Alabama and the country are to move into the 21st century with a population that can be educated and can do work that needs to be done, logic mandates that all babies should get a healthy start.

Expanding Medicaid coverage to 100 percent of the federal poverty level, which began in Alabama this past July and is soon to be federally mandated, will begin to address the problem of access to care.

Ensuring access to prenatal and follow-up care will improve the infant mortality rate, according to countless studies and experience in other areas of the country.

But in addition to Medicaid coverage, it seems that innovations must be put in place to get women and babies to doctors, to teach mothers about babies' needs, to make sure they are using the programs available and to make family planning a mainstay in our society.

Luckily, addressing the infant mortality problem can have a ripple effect in many troubled areas - teen-age pregnancy, medical malpractice costs, education, productivity and economic development.

A Death In The Family

Alabama's Infant Mortality Crisis

Alabama's babies are dying. Last year, 788 infants in the state did not make it to their first birthday.

That grim statistic means Alabama has the highest infant mortality rate of any state in the nation.

During an intensive 3-month investigation, The Alabama Journal examined the complexities of the tragedy. The result was a tale of poverty and human suffering — a story of a state with misplaced priorities.

A weeklong series of articles resulted from the investigation. That series, which was first published in The Journal Sept. 14-18, 1987, is reprinted here.

THE ALABAMA JOURNAL

A Death In The Family

For some, death comes at an early age

THE PROBLEM

By Susan Eggering
Journal staff writer

The photo album tells the story.

There, beneath sheets of protective plastic, lie Tarneisha and Sixneisha Lewis, frozen in 3-by-4-inch glossy Polaroids. In identical caskets of baby blue, they are stiff and cold, unable to feel the warmth of the blankets that swaddle their tiny bodies.

The terse newspaper blurbs beneath the photos announce to the world their deaths.

A handful of photos. A few scraps of newsprint. They're all that's left to remind Eutaw mother Josephine Lewis of her twin girls. That, and the question that will remain unanswered forever: Why?

Why did they die? Why did they become two more statistics in Alabama's infant mortality crisis?

Josephine, 24, can only think it was the will of God. It is this knowledge that makes the losses bearable. It is this knowledge that she would share with another mother agonizing to understand the reason behind an infant's death, a death in the family.

"Only thing I could tell her is like what everybody's been telling me," Josephine said. "It was God's will. Maybe he took them for a reason."

Josephine's story, in many ways, is the story of the hundreds of infant deaths that occur each year in Alabama. Each baby who dies lives on only as a statistic, a pathetic sort of immortality.

Alabama has the highest infant mortality rate of any state in the nation, outranked only by concentrated pockets of poverty in the District of Columbia. For every thousand Alabama babies born in 1986, 13.3 failed to make it to their first birthday, according to the state Bureau of Vital Statistics.

Only a dozen years shy of the 21st century, those grim statistics put the state on a par with developing nations in terms of quality of life.

"We're talking about Third World conditions right here in Alabama," said Dr. Roseanne Cook, the sole physician staffing the Pine Apple Rural Health Clinic in Wilcox County. "You don't have to go to Africa or South America to see Third World conditions. They're right here in the rural South. All you have to do is drive through the county, open up your eyes and visit a few homes."

While government office buildings in Montgomery hum with state-of-the-art computers and researchers in Huntsville probe the mysteries of celestial travel, our babies continue to die.

For Alabama has been unable, or unwilling, to ensure a basic right to its youngest citizens — the right to a fair shot at life.

Last year, of the 59,441 births in the state, 788 infants died. And there will be many more funerals in the years to come unless the state acts decisively to save its children.

The problem is a critical one. During a three-month investigation of infant mortality, The Alabama Journal found that:

- Infant deaths can be dramatically reduced if the state only will make the commitment.
- Infant mortality is directly linked to poverty, poor education, lack of transportation and insufficient access to medical care both during pregnancy and after birth.
- It costs much less to provide medical care for pregnant women than to pay the hospital and medical bills of the underweight and handicapped infants often born to women who receive no prenatal care.
- The poor, who are the main victims of infant mortality, have no political spokesman to bring their cause to the attention of legislators and others who could rectify the problem.
- Without help from the Legislature, the vicious cycle of poverty, illiteracy, teen pregnancy and inadequate medical care will continue unabated generation after generation.
- The Legislature has paid little more than lip service to the problem even though infant deaths have plagued the state for years.
- Alabama has funded such ventures as the Alabama Shakespeare Festival and dozens of local festivals honoring everything from chitlins to blueberries while ignoring a life-and-death issue.
- The infants of Medicaid mothers have a much better chance of surviving than do the babies of women who have no money, insurance or financial assistance of any kind.
- Other states with social problems similar to those in Alabama have confronted the problem head-on and have succeeded in reducing their infant mortality rates.
- The ramifications of infant mortality extend beyond the affected families to the state as a whole. Industry interested in locating in Alabama looks at quality-of-life indicators, and a high infant mortality rate is an automatic strike against a state.
- The typical mother whose child becomes an infant mortality statistic is young, single, poor and, very often, black.

Consider a profile of such a woman: She probably has not visited a doctor at all or only infrequently during her pregnancy. The doctor who delivers her child doesn't know if she has a history of hypertension and diabetes in her family — most common among poor black families.

She seldom eats a well-balanced diet, and she is more likely to give birth to a low-birth-weight or nutritionally deprived infant, ill-equipped to survive the first year of life.

Providing medical care to all pregnant mothers would go a long way toward solving Alabama's infant mortality problem, doctors say. But such a simple, common-sensical, preventive approach lacks the appeal of high-tech medicine.

"It's not glamorous to provide prenatal care," said State Health Officer Dr. Earl Fox. "It is exciting to see a 1-pound infant kept alive on a respirator, but it's much more expensive."

It costs on average $1,000 a day to keep a baby in a neonatal unit. And though many don't realize it, this is a cost that all taxpayers ultimately share, Fox said. The prudent thing to do would be to invest in preventive care.

"This is an issue in my mind where there's a lot of return for the money," Fox said. "For every dollar spent on prenatal care, $3.38 is saved in the short term and more in the long term. The issue is not are we going to pay for it. We're already paying for it. The issue is really only what we're going to pay for and how we're going to pay for it."

But little money has been allocated for such things in the past. Though infant mortality is far from a new problem, state lawmakers are just now beginning to take an interest in the issue. There's been speculation that the complaints of those affected by infant mortality have gone unaddressed for so long because they constitute no valuable voting bloc, have no political clout.

"It hasn't been an issue up until now," Fox said. "I don't know why."

The reason no one has made infant mortality an issue may be simple. It is a complex problem. There are no parades and precious few cheers for those who try to save babies.

Yet much can be done. Studies have documented that babies of Medicaid mothers — the poorest of the poor in Alabama — are less likely to die after a year of life than their richer counterparts.

But in Alabama, to be eligible for Medicaid, a family of three can earn no more than $118 per month. In bureaucratic terms, that's 16 percent of the federal poverty level. In the real world, that's 97 cents per day for each person.

No other state has a lower Medicaid eligibility standard.

Tommy McDougal, executive director of the Alabama Hospital Association, joins virtually every other health expert in the state in contending that Medicaid should be expanded. However, he concedes the problem cannot be solved solely by expanding the program.

"The number of people eligible in the state for the last five years has increased," he said, "yet the number of people getting benefits has dropped in the last five years. I think it's a failure to make it as easy as possible to get into the Medicaid program. We've sort of had the mentality in this state to hold the line and not spend any more dollars."

Other states have successfully implemented programs which have significantly reduced the rate of infant mortality.

Rather than protesting that funds for reducing infant mortality are too costly for their limited means, Mississippi, South Carolina and Kentucky have implemented an array of wide-ranging, inexpensive and innovative programs.

In fact, Mississippi, long at the bottom of almost all indicators of health care, has surpassed Alabama in the battle against infant mortality. Through a number of programs, the state dropped its infant mortality rate from 14.4 infant deaths per 1,000 births in 1984 to 12.3 in 1986.

South Carolina also has established programs that lowered its infant mortality rate below Alabama's.

And seven years after Kentucky watched its infant mortality problem reach critical proportions, the state's infant mortality rate has been reduced by nearly 30 percent.

By not correcting the problem, the entire state of Alabama — not just the poor — will continue to suffer, for the problem is multifaceted. It is an issue at once economic, legislative, health-related, social and moral.

"I think we have a moral responsibility," Fox said. "However, in the end, everything gets reduced to economic terms. I think this is one of those things that is right and humane and moral to do, but it's also efficient from a cost standpoint."

By not doing anything, more than just huge debts are incurred.

"When babies die, that's an early warning signal that something is greatly wrong in the society," said Christiane Hale, director of the maternal child health program at the University of Alabama at Birmingham. "Half the babies don't have to die. That's a personal tragedy."

Potential income is lost because industries have no interest in relocating to a state where even one or two quality-of-life indicators are poor.

"We take every opportunity to get mothers to seek out prenatal care," said Calvin Michaels, personnel director for Burlington Industries of Greensboro, N.C. "Of all the things that can be done, prenatal concern is number one. We would like to know employees have access to all medical care if we were locating a plant. That's always on our checklist."

The time to do something is now, according to Fox, who has a two-fold plan of action in mind. What's needed, he said, is financial aid plus the development of a statewide system to provide prenatal and postpartum care to all women who currently are not receiving it. Each is essential.

"You need the financing and the system," Fox said. "I look to Medicaid for the funding. You've got to have a system (too). That's where I see the (public) health departments coming in."

While Fox has mandated within the past nine months that all of Alabama's county health departments provide prenatal care, the problem remains that there is inadequate physician support for the public health nurses, he said.

(Please see DEATH Page 3)

Journal photos by Jay Sailors

Photos remind Josephine of loss

Death

But by taking advantage of matching federal funds, the cost of implementing a program to combat infant mortality would not be prohibitive.

"Because Alabama is so poor, all it has to do is pay 28 cents to buy a dollar," Hale said. "It's the best bargain around. Alabama may be facing its last chance to move in a cost-efficient way."

Once people understand the true nature of infant mortality and the feasibility of reducing it, they will be eager to help, Fox said. And improvement will be visible in just a few years.

Maybe then the needless deaths that plague families like Josephine Lewis' will cease.

Until then, babies will continue to die needlessly, their only legacy one of parental heartache and cold statistics.

That, and perhaps a handful of photos, a few scraps of newsprint.

Journal staff writers Frank Bass, Emily Bentley and Peggy Roberts contributed to this story.

1986 state infant mortality rates

HIGHEST	
STATE	RATE
Alabama	13.3
S. Carolina	13.1
Georgia	12.3
Louisiana	12.1
Illinois	11.8
N. Carolina	11.7
S. Dakota	11.6
Mississippi	11.5
Missouri	11.4
Tennessee	11.4

LOWEST	
STATE	RATE
Wyoming	6.87
Montana	6.95
N. Hampshire	7.21
Maine	7.68
Iowa	7.94
Mass.	7.95
Vermont	8.23
Kansas	8.32
Wisconsin	8.88
Oregon	8.92

Source: National Center for Health Statistics — Journal graphic by Phyllis Perry

County infant mortality rates*

HIGHEST	
COUNTY	RATE
Wilcox	34.2
Butler	26.4
Bullock	26.2
Choctaw	25.1
Chambers	24.5
Monroe	23.9
Pickens	23.8
Marengo	21.1
Coosa	19.9
Autauga	18.9
Hale	18.9

LOWEST	
COUNTY	RATE
St. Clair	1.6
Jackson	3.1
Bibb	4.7
Crenshaw	4.9
Greene	5.5
Escambia	5.7
Clebume	6.2
Covington	6.5
Geneva	6.6
Elmore	7.3
Conecuh	0

Source: The Bureau of Vital Statistics of the Alabama Department of Public Health — Journal graphic by Phyllis Perry
*As of July 31. Deaths per 1,000 Births

Twins' deaths point to state's social problems

By Susan Eggering
Journal staff writer

EUTAW — From the yard come the robust cries of neighborhood children at summertime play. But inside the brick house, all is quiet, still. The mother, a tired 24, sits in the dim front room, a photo album open before her.

Most of the memories preserved between the album's covers are of pleasant, happy times. But the pictures of Josephine Lewis' twin girls only bring sadness to their mother. These pictures are not a celebration of life, but a reminder of death.

Yet she will keep them, even treasure them, for they are all that she has left of Tarneisha and Starneisha Lewis. Both died before reaching their first birthday — two more of Alabama's infant mortality statistics.

Josephine's case is not that unusual.

Numerous extenuating circumstances made hers a high-risk pregnancy according to Dr. Sandral Hullett, her delivering physician.

Like all pregnant patients who come to Eutaw's West Alabama Health Services, Josephine was rated on a numerical scale. She received points for those pre-existing conditions she had which, doctors know, increase a baby's chances of dying before its first birthday.

Ten is high.

"Her risk scale shows she had a risk factor of 25," said Hullett, health services director at the clinic, as she glanced at Lewis' patient file.

Her high-risk factor was no surprise given Josephine's background.

She was a sophomore in high school the first time she became pregnant. She had five children by the time she was carrying the twins at age 22. She never finished high school, never married. Her income remains minimal, borderline poverty.

One of her children required a transfusion after birth due to jaundice. A risk of premature birth, hypertension and anemia associated with previous pregnancies pushed her risk factor still higher.

Despite her troubled medical history, Josephine did not seek out prenatal care until almost her third trimester with the twins, Hullett said. She came in only twice to see a doctor before she delivered.

This inattention was not unusual. Transportation was difficult. She owned no car and had to depend on family and friends to get into town to the clinic.

Josephine's nutrition was less than adequate, so she did not gain the expected weight. In fact, maternity clothes were completely unnecessary as they had been with her previous pregnancies, she said. Nutrition simply was not a high priority.

"I just wouldn't eat no liver or drink no tomato juice," she said.

She was only in the 24th week of what should have been a 40-week pregnancy when she delivered prematurely on Oct. 3, 1985.

By the time Josephine arrived at the hospital, she was so far along in labor that Hullett had to deliver the twins in the corridor.

Tarneisha, who weighed only 2 pounds, died 30 minutes after birth. Her lungs were simply too immature to sustain her, Hullett said. Starneisha, who weighed a half pound more, remained in the newborn nursery for two months until she tipped the scales at 5 pounds.

"Then I got to bring her home," Josephine said.

Things were fine the first couple of weeks, and Josephine was careful to follow Hullett's instructions about when and how to administer drops of medicine to regulate Starneisha's sometimes erratic heartbeat.

"She got so she was growing," Josephine said.

The baby's premature clothes no longer fit. Things were looking up.

Then, a few days after Christmas, on Dec. 28, Josephine couldn't wake Starneisha at feeding time.

"I thought she was just sleeping," she said.

She tried to rouse her, but the infant wouldn't budge.

"Usually when I picked her up, she'd wiggle and move, so I knew she was okay," Josephine said.

But this time she didn't. Couldn't. She was dead. The cause of death — unknown and undeterminable — was attributed to the catch-all Sudden Infant Death Syndrome, Hullett said.

For Josephine, it was the second tragedy in less than three months.

"It just really shocked me," she said. "I couldn't believe this could happen to me. It isn't fair."

Her fiance, the father of the twins, was devastated.

"He took it more harder than I did," Josephine said.

Seven-year-old Lashanda, Josephine's oldest child whom she has "adopted out" to her mother, was told that Starneisha had died. But Josephine's other children thought for a long time the baby was just in the hospital. They periodically pestered their mother about when the baby would be coming home.

Josephine couldn't tell them the truth.

Life — somehow — goes on.

She has had another child.

Josephine now cares for Carlos, 5, her 4-year-old twins, Santeini and Anteini, Dominique, 3, and Ashley, 11 months.

She does what she can with what little she has. Colorful photos of the family are hung all around in an attempt to brighten the drab walls of the small, government-subsidized house. In another room, Josephine has created a makeshift shrine of sorts, surrounding a large picture of Jesus with a border of red yarn.

The house is livable, nothing more. The battered screen door requires a Herculean push to open and close. Some of the living room furniture is stained and worn, the rest of it shrouded beneath mismatched covers. The air smells faintly of stale urine.

Although Josephine's life as a full-time mother is busy, her thoughts still turn occasionally to the baby girls she lost. If they had lived, they would have rounded out her boisterous brood and given her a matched set of twins — one each of boys and girls.

Josephine and the dead twins' father continue to cope with the loss of the babies.

"We talk about it a lot," Josephine said, "and go visit the graves and take flowers and clean them off."

Despite her troubled medical history, Josephine did not seek out prenatal care until almost her third trimester with the twins. She came in only twice to see a doctor before she delivered.

Sandral Hullett, Josephine's delivering physician

Josephine Lewis
... 'I thought she was just sleeping'

'It's not a health problem; it's a social problem'

It was considered a national tragedy in 1963 when President John F. Kennedy's third child, born prematurely, died because his underdeveloped lungs weren't strong enough for him to breathe on his own.

Patrick Kennedy was a child who would have had everything.

First Lady Jacqueline Kennedy had the best prenatal care that money could buy, and when the infant arrived early, he had the attention of the best pediatricians in the world.

After the boy's death, the U.S. medical community was determined to whip the high infant mortality rate in the most technologically developed country in the world.

But 24 years of medical advancements haven't done much to help poor Alabamians keep their babies alive.

"It's not a health problem; it's a social problem," said Dr. Christiane Hale, director of the maternal child health program at the School of Public Health at the University of Alabama at Birmingham.

Hale said most of the nearly 800 Alabama babies under age 1 who die annually are born into poverty-stricken families; half of all babies born in Alabama are born to poor women.

Hale said infant mortality is likely to occur in families or in communities where living standards are poor. "It is an indirect measure of water and housing quality, education and the community's will to provide welfare," said Hale.

"I think there's good reason to think these risk factors will perpetuate from one generation to the next," she said.

What follows are the stories of two Alabama families.

One has known the pain of almost losing a baby, but the family had insurance and access to doctors and a big-city hospital. Their child survived.

The other family, snared in the web of rural poverty, has followed the caskets of generations of babies to a country-church graveyard.

Two families — the Parrishes and the Nelsons.

Two portraits of life and death in Alabama.

A Death In The Family

A baby boy, healthy at birth, dies amid a cycle of poverty

By Peggy Roberts

BAKER HILL — Mamie Gene Nelson's 2-month-old son, Roy, didn't move when she tried to wake him one afternoon in March.

The youngest of four children belonging to the 21-year-old woman, Roy had been napping in a drafty bedroom — even colder than usual because of an unseasonably late freeze.

"I didn't know what was wrong," said his mother, recalling the day she desperately tried to shake her baby out of his sleep. "He didn't move. He didn't breathe. He was dead."

An autopsy revealed Roy died of pneumonia.

Roy had been a robust baby when he was born in a Dothan hospital two months earlier, but his newborn system wasn't strong enough to endure the conditions in the home where his mother brought him.

Baby Roy was buried in a church cemetery along with other members of his extended family.

After Roy's funeral, the family returned to the normal routine of worrying about whether there would be enough money to keep the remaining children alive.

Nineteen youngsters share Mamie Gene's dilapidated country hovel in Baker Hill, near Eufaula. Three of them belong to Mamie Gene, and there are her mother's younger children, her sister Willie Mae's children and the children of a sister who died of leukemia a few years ago.

The children range in age from their mid-teens to less than a year old. The mothers call the youngest children "knee babies" because, when these children stand, they only reach their mothers' knees.

In the winter, the wind whips through the house because there isn't any dry wall to cover the boards of the unfinished walls. Some windows are missing panes, and the floor is patched together with squares of aluminum sheeting covering holes.

In all, 22 people live in the house. There aren't enough beds, so most of the children sleep on the floor.

Right now the family survives on about $500 welfare per month and food stamps, when they can get them.

And Willie Mae is pregnant again.

The matriarch of the family, 74-year-old Cinderella Ross, has watched this cycle of life and death played out on a stage of poverty and hunger.

The literary character for whom she was named is rescued from her suffering by a handsome prince, but in a cruel twist of fate, Cinderella Ross has remained poor all her life. Happy endings, it seems, are for fairy tales.

Baby Roy, the latest baby to die in the family, was Cinderella's great-grandchild.

If they were asked to explain to Cinderella why so many babies like Roy have died in her family, medical experts and sociologists might offer the following: Once the tragedy of infant mortality hits a family, it is likely to take another life — either in the same generation or the next.

Cinderella's family could be a case study.

> Although she mourns her losses, Cinderella talks about the deaths as though they couldn't have been prevented

Cinderella had 14 children, but only five are still living.

Like Baby Roy, some of them caught pneumonia and died. "And it was no wonder in the house we lived in," she said. "You could lay in the bed and count the stars."

Cinderella now lives about two miles from Mamie Gene's house. She reared her eldest daughter's children after the 27-year-old woman died at home during childbirth.

"That baby lived," she said. "He nursed his mother for 30 minutes after she was gone. Now he's 21 years old."

Although she mourns her losses, Cinderella talks about the deaths as though they were circumstances that couldn't have been helped.

Life at this level is difficult in the best of times. Even the $50 she is charged to bury each loved one in the church cemetery is a major burden.

"It's tough for us out here," she said. "But we do the best we can."

She doesn't worry that Roy's death might have been prevented by a trip to the doctor. She said that without money, poor folks can't get good medical care for their children.

"Unless you got the money, you can't get waited on," she said.

She doesn't expect to get medical care. In her rural community, people are born and die all the time.

"I have 52 grandchildren, 37 great-grandchildren and 26 great-great-grandchildren," she said proudly. "We make it somehow."

Blessed with the best medical care, a premature baby beats the odds

By Peggy Roberts
Journal staff writer

Richard Earl Parrish weighed 2 pounds, 2 ounces when he was born prematurely May 31, nearly 10 weeks before he was due.

His mother, Jackie, a 35-year-old who had never been pregnant before, was considered at high risk for delivery complications. And she might have lost the small infant had she not been rushed during labor from a hospital in Opp to Montgomery, where she gave birth at Baptist Medical Center.

By normal standards, the baby didn't have much chance of survival. But he thrived in the hospital's neonatal intensive care unit. And seven weeks after he was born, he went home with his parents to Kinston.

"We feel like if it weren't for the doctors and nurses in this unit, he might not have made it," said Jackie, clutching the hand of her husband, Emmett.

The Parrishes had just about given up their hopes of having a child and were considering adoption when Jackie got pregnant.

She didn't discover she was pregnant until she was four months along — a high-risk factor in her pregnancy. Jackie thought she simply was recovering from a bout with the flu.

Delighted at the news, her husband asked her to quit her job as a seamstress in a south Alabama textile plant to concentrate on having a healthy pregnancy.

"Everything went fine all the way through, until the baby was born early," she said. "I never even had morning sickness."

Jackie remembers having four or five ultrasound examinations (tests that show the baby's development on a screen) on her frequent trips to the doctor's office. "Some of them were to keep a check on me and the baby, and some were just for fun," she said.

In late May, she was progressing normally and felt relaxed knowing that her husband's health insurance policy, from his job as a store manager for IGA, would take care of the expenses.

Then, on May 29, her water broke.

"I went into the (Opp) hospital, where they told me I'd have to stay flat on my back in bed for the last six weeks unless I went into labor," Jackie said.

Her doctor feared infection when she developed a fever, and he sent her in an ambulance to Montgomery, where she delivered the following day.

"At first, the doctor was real concerned that the baby would have an infection or his respiratory system would be too underdeveloped to make it," she said. "But he turned out to be in better shape than the doctor thought."

During the first few days, Richard Earl's blood sugar climbed dangerously high. But close attention by the medical staff in the neonatal intensive care unit pulled him through the crisis.

The Parrishes are liberal in their praise for the care their child received at the neonatal unit. Baptist Medical Center is "the greatest place," said Jackie, the more talkative of the couple.

"So many babies wouldn't have a chance if it weren't for this place," she said. "I just feel like they can do so much if they can catch a baby in time."

During Richard Earl's stay in the hospital, his parents drove two hours from their Kinston home at least three times a week to spend the morning with their new son.

Although it seemed forever between visits to Montgomery, the Parrishes were sure that their baby was getting the best care possible. Because their baby didn't have as many complications as many premature infants, his parents considered tranferring him to the hospital in Opp, closer to their home. But they decided that was too risky.

Just before the baby was discharged from the hospital, he was transferred to the pediatric unit, where his parents stayed with him for several days while learning to care for a premature infant.

"We had to learn CPR and how to work the heart monitor," said Jackie, noting that they took the apparatus home with the baby.

Their insurance will pay most of their hospital bill, which likely will top $30,000.

Jackie said just knowing they wouldn't have to pay a crippling medical bill has helped.

"The bill we got for the first month was over $22,000," she said. "There's no way we could come anywhere near handling that if it weren't for the insurance."

The proud parents have nothing left to worry about — except how to keep from spoiling their son.

Black babies more likely to die than white counterparts

By Susan Eggering
Journal staff writer

It is a given, when dealing with the topic of infant mortality, that blacks in Alabama are at greater risk of losing their babies than whites.

The numbers say so.

Infant deaths are nearly twice as high among blacks as among whites throughout the country, according to Christiane Hale, director of the maternal child health program at the University of Alabama at Birmingham. Hale has studied national infant mortality rates from 1900 to the present.

"It's one of the most astonishing, constant relationships we see," she said. "At any time and any place, the infant mortality rate will be twice as high among blacks as among whites."

Statistics from the state Bureau of Vital Statistics clearly indicate this.

In 1986, of the 788 Alabama babies who died before they reached their first birthday, 374 were white and 414 were non-white, a category that is 98 percent black, said Dale Quinney, director of the bureau's Division of Statistical Analysis Services.

While only 40 more black babies than white babies died, the figures must be viewed in the context of the number of babies born to each race. Whites had more babies than blacks, but blacks lost more babies proportionately than whites.

The number of deaths translates to a rate of 9.7 deaths per 1,000 live births for whites, while the corresponding rate for non-whites is 19.9.

Alabama's population is 76 percent white, 23 percent black and 1 percent Hispanic.

But infant mortality is not a "black" or racial problem. Rather, experts say, it is an economic problem — one that arises out of poverty and poor access to medical care.

"They're poorer," said Dr. Roseanne Cook, a physician in Wilcox County. "It has to do with economics."

Jim Coleman, director of West Alabama Health Services in Eutaw, agreed.

"To me, it's not so much race but the economic index," he said.

Blacks were not guaranteed the right to vote until the 1960s and have often been relegated to the lowest-paying jobs. Generation after generation, they have been trapped in a cycle of poverty, teen pregnancy and welfare. Even today, they continue to struggle against the economic hardships in the wake of decades of racism.

Although she cannot prove it scientifically, Hale suspects that the effects of poverty linger on even long after a family breaks out of its vicious grasp.

A study done in 1980 seems to support this. It compared a group of black and white women, all of similar background. They were each between 25 and 29 years of age, had four years education past the high school level, were married and had had successful first pregnancies, Hale said. Yet the black women had a much higher percentage of low-birth-weight babies — 5.5 percent — when compared with the whites — 2.8 percent.

One of the major problems remaining today is that the system of prenatal and postpartum health services available to poor blacks is simply not adequate, Coleman said. "We have too many people falling through the cracks," he added.

"Let's face it," he said. "Why do we have the so-called best health care system in the world and such a high infant mortality rate?

"If you have money, you can get the best care there is. If you don't, you can't."

Even where services for the poor exist, the system is fraught with layers of bureaucracy that can scare, confuse and tire potential clients.

"What the average person needs to do is pretend he is poor and see if he can interface with the human service organizations," Coleman said. "You spend all your time going from one to another. The programs are not designed to make it convenient for the individual. That's the real problem with the health-care delivery system."

But even when health services are available, black women sometimes don't seek out prenatal care.

"A lot of it is cultural and just not knowing the importance of it," said Dr. Sandral Hullett, health services director at the Eutaw clinic.

Many don't fully understand the significance of pregnancy.

"People take it for granted that when they're pregnant, they're going to have this wonderful baby," she said. "It doesn't always happen that way."

Whatever the reason, as a direct result of receiving little or no prenatal care, poor black mothers tend to have low-birth-weight babies — the babies who are at highest risk of dying.

"Low birth weights among the black population tend to be a problem, and low birth weights are a major contributing factor to infant mortality," said State Health Officer Dr. Earl Fox.

Little has been done to combat infant mortality in Alabama in the past, Fox said. There simply hasn't been much interest.

Only at the end of this year's legislative session did lawmakers begin to express any interest in the issue.

When asked whether, as a black legislator, he felt he had a greater responsibility than whites in fighting infant mortality, Sen. Hank Sanders, D-Selma, replied, "No."

"I've never had any citizen raise the issue with me," Sanders said.

"I feel I am particularly sensitive to the issue, but I don't feel the responsibility should be allocated to black legislators," he said.

"I think it's a poor people's issue."

What needs to be done is to develop a health care system that is a partnership between public and private sectors, Coleman said.

"The public sector and the private sector are going to have to work together to solve these issues," he said. "Government alone cannot solve it, and the private sector can't do it alone either."

But more than accessible health services is needed to lower Alabama's infant mortality rate, Coleman said.

"Money alone is not going to solve these problems," he said.

Needed as well are self-help health classes in schools to encourage the next generation of parents to take care of themselves. In addition, increased job opportunities and better training in usable skills are necessary.

And for those who question the fiscal soundness of such measures, Coleman is quick to point out that prevention is the most cost-effective measure when it comes to infant mortality and other health issues.

"If we could spend more time, energy and money on prevention, we could really reduce the cost of health care," he said.

Journal staff writer Emily Bentley contributed to this story.

Infant mortality rates by race

NONWHITE			
YEAR	NO.	ALA. RATE	U.S. RATE
1940	1,869	77.9	73.8
1950	1,529	46.4	44.5
1960	1,345	44.7	43.2
1970	790	35.8	30.9
1980	488	21.4	19.1
1986	414	19.9	-2

WHITE			
YEAR	NO.	ALA. RATE	U.S. RATE
1940	1,993	51.1	43.2
1950	1,475	29.7	26.8
1960	1,258	24.7	22.9
1970	838	18.4	17.8
1980	472	11.6	11.0
1986	374	9.7	-2

Source: The Bureau of Vital Statistics of the Alabama Dept. of Public Health

Journal graphic by Phyllis Perry

Christiane Hale
... Did infant mortality rate study

Roseanne Cook
... 'It has to do with economics'

Wilcox County has state's highest infant death rate

By Susan Eggering
Journal staff writer

CAMDEN — A trip to Wilcox County makes a visitor feel like a time traveler who has stumbled upon a piece of the past better left undisturbed.

Leaving behind the air-conditioned comforts of a modern city to enter this hot, dusty pocket of southwest Alabama is like walking from a slick color film into a grainy black-and-white movie peopled with characters from a Steinbeck novel.

Life is hard here in the best of times.

The rural county has the highest infant mortality rate of any county in Alabama. And in Alabama, more babies fail to make it to their first birthday than in any state in the nation.

Wilcox County's infant death rate is nearly three times that of the state as a whole and much worse than that of developing countries like Cuba, Panama and Costa Rica. Like them, this county of pasture land and timber seems to belong to a time less advanced. Even in Camden — the largest town and county seat — life seems slower-paced, somehow backward. There is no bustle, none of the familiar commercial bric-a-brac that makes one city seem the mirror image of another.

Church's Fried Chicken and Ted's Drive-In are the only fast-food eateries in town. Public telephones are scarce and neon signs nil. There are few retail stores and no movie theaters. Even radio reception is poor.

So the 2,400 residents make do with simpler pleasures. Folks go fishing on the Alabama River or at the backwater up at Millers Ferry. Men in faded overalls lounge outside gas stations and tired country stores, so comfortable in their friendship they need not even speak to pass the time. Those who can afford it play golf at the state park. Those who can't do without.

Life is pleasant here for the gentry who have the money to enjoy it. But for the thousands who do not, maintaining a minimum existence is a struggle in this hamlet of the haves and the have-nots.

With its paradoxical blend of pastoral beauty and bitter poverty, Wilcox County represents the twin faces of rural America.

Rich and poor live side-by-side here in mutual exclusivity. Majestic manor homes rise heavenward while neighboring tumbledown wooden shacks struggle to keep from crumbling into nothingness.

"The Quarters," a particularly desperate section of Camden, is reminiscent of the squalid conditions endured by California migrant workers and documented in the Depression-era photos of Dorothea Lange.

In 1984, Wilcox County was listed as one of the nation's 10 poorest counties, with 45.3 percent of its residents living below the poverty level, according to one national survey by a newspaper.

Living conditions for at least 50 percent of the population are atrocious, according to Dr. Roseanne Cook, a nun in the Roman Catholic order of the Sisters of St. Joseph. Cook is the sole physician staffing the Pine Apple Rural Health Clinic and one of only four doctors who serve the county's residents.

"We're talking about walls that are paper thin that have cardboard holding them together in places," she said. "We're talking about floorboards that have rotted, porches that are falling off, screen doors that are full of holes, very dim rooms with a bare light bulb.

"Most are filled with wall-to-wall beds. They heat them with a pot-bellied stove or a fireplace. If they have water in the house, it consists of a garden hose coming through the window into the sink," she said.

Outside the tin-roofed shacks, mangy dogs scratch at ever-present fleas. Flies are constant companions of the barefoot children who play in the heat, and their brown arms and legs are covered with bug bites.

(Please see WILCOX Page 7)

A Death In The Family

Wilcox

Yet these youngsters are the lucky ones, those hardy enough to exist in a place where survival of the fittest is nature's ruthless form of population control.

Others are not so fortunate. Of the 263 babies born in Wilcox County in 1986, nine infants — eight black, one white — failed to make it to their first birthday, according to statistics from the state Bureau of Vital Statistics. That means that for every 1,000 babies born in the county, 34.2 will die before they turn 1. That gives Wilcox County the highest infant mortality rate in the state.

"You know, it's a mammoth problem," Cook said. "I don't see any easy solution, but I do see if there can be economic growth in the area, infant mortality will go down. Because people don't like to live like this."

The job situation has not always been so bleak for the 15,000 — 70 percent of them black — who call this county home. Once, much of the 998 acres of Black Belt land was filled with crops like cotton, which required many hands to help with harvesting.

Today, however, this fertile land that is crisscrossed by 155 miles of winding river is used by MacMillan Bloedel, Scott Paper Co., Georgia Pacific and International Paper Co. They grow timber for paper products and lumber. That's hardly a labor-intensive industry.

Between 1,250 and 1,300 people from Wilcox and surrounding counties are employed by the MacMillan Bloedel paper mill, the county's largest employer. Approximately 150 are employed by a shirt factory in Camden, and another 150 to 200 work for D.J. Apparel, a clothing factory also located in Camden. But 13 percent to 14 percent of Wilcox County residents remain jobless, according to County Commission Chairman Charles Hayes.

Many remain unemployed so long that discouragement inevitably settles in. After awhile, they no longer even bother to look for work.

It's not a matter of apathy.

"We've got a good work force," said Dr. Sumpter Blackmon, a general practitioner who has worked in Wilcox County for the past 17 years.

"They want to work, and they have the aptitude to do it. Damn," he said, "there are just no jobs."

High unemployment joins forces with poverty and sickness to hold the population hostage in an iron stranglehold.

As with a row of dominoes that topple one after another, when one quality-of-life indicator is affected, so too are the rest.

"The poorer your poverty (level), the higher your disease (rate) and your infant mortality," Cook said.

With few jobs, money is scarce. Cars, therefore, are a luxury many cannot afford. And so access to medical care becomes difficult.

"These people are out in the middle of nowhere," Cook said.

A friend may charge as much as $20 to bring a neighbor to a clinic.

Even knowing someone who has wheels, though, is not always enough. Those who do own automobiles often spend more time fixing than driving them. Many are jalopies whose rusted bodies look better suited for scrap metal than family transportation.

So even though prenatal care is available and free of charge, many women have no way of getting to town to take advantage of it. The situation is further worsened by the fact that prohibitive malpractice insurance rates forced doctors in Wilcox County to stop delivering babies almost two years ago. Expectant mothers now must travel from 30 minutes to two hours to reach facilities in Montgomery, Selma, Thomasville, Monroeville or Luverne.

Some don't make it.

"A lot deliver in the car," Cook said. "A lot deliver in the emergency room ... and are sent home within a couple of hours."

Many times, the doctor has never before seen the woman and knows nothing of her medical history.

Restricted access to prenatal and delivery services, together with a lack of medical facilities, poor hygiene and education, inadequate nutrition and the widespread poverty of the area, all contribute to the high infant mortality rate, she said.

"There's no one reason," Blackmon said. "It's just a complicated combination of problems. I think that the situation has obviously gotten worse since we were forced to stop delivering babies at this (J. Paul Jones Memorial) hospital. Folks have to travel 40 or 50 miles. Transportation is a real problem."

In the first nine months she worked at the clinic, Cook estimates she saw 30 to 50 babies under age 1 who were suffering from such conditions as anemia, intestinal parasites, malnutrition, ear infections, tonsilitis, strep infections, infected bug bites and impetigo (infected skin sores).

"It's not that mothers are negligent," she said. "It's just that they don't have the resources or knowledge."

Joyce Conn, nursing supervisor at the Wilcox and Dallas County Health Departments, agreed.

"I think this is the real root of the problem — a knowledge deficit of the importance of prenatal (and postpartum) care."

The struggle for the basic necessities of life — food and shelter — takes precedence for these folks, said general practitioner Dr. James Nettles, one of the 12 founders of the

J. Paul Jones Memorial Hospital in Camden.

"Preventative care in Wilcox County is relatively unimportant," he said. "It doesn't have a high priority in the single-parent family. And the reason is that as breadwinners, they (single mothers) don't have time, and they don't see the immediate results of it, so they only spend money when it becomes absolutely necessary, and it becomes a 'sick' problem. Unless they're encouraged, they don't worry about it."

Many of the mothers are just kids themselves. Blackmon has delivered babies to many girls who were only 14 and some even as young as 13.

It is this lack of early childhood care, inextricably tied to a social system that condones single motherhood, that is directly responsible for high infant mortality rates, Nettles said. Illegitimacy is rampant.

"Five years ago, I did a survey, and it (the illegitimacy rate) was 88 percent," he said. "During the 10 years I reviewed, it had gone up from 65 percent to 88 percent."

In addition, Wilcox County has always had one of the world's highest fertility rates.

"It's not unusual in this county (for a woman) to have six, eight or 10 children," he said. "There'll be three or four different fathers of these children."

Women are not motivated to change their ways because they receive aid for each child they have out of wedlock.

"Approximately 40 percent of the cash flow in this county is from welfare or some type of government give-away program," Nettles said.

He added, "The way the government-aid program is so designed, the one who perpetuates the high infant mortality (rate) is being rewarded, and the one who is getting married is being penalized."

Prenatal care, hospitalization and doctor's fees for pregnancy, delivery and postpartem care for mother and baby average about $2,500. If a couple is married, the husband and wife must come up with the money themselves if they don't have insurance.

"If they live together as man and wife and are not legally married, our social welfare services will pay it all, and if she gets sick afterward, they will send a nurse," Nettles said.

He added, "It's stupid to think that we wouldn't have a high infant mortality rate with this social system."

In his 37 years of practice, the 65-year-old physician has diagnosed infants with meningitis, measles, complications from chicken pox, pneumonias of varying types and urinary tract infections. Most such conditions are entirely preventable, he said, some by just a simple vaccination. But such preventive care requires foresight on the part of the parent, as does recognizing a potential illness in its early stages when it is easily treatable.

"It's a lack of knowing what signs and symptoms to look for," Cook said. "... So when the child does get to see you, the child's pretty bad off."

Such tragedies are not, she said, due to stupidity or intentional negligence on the part of the parents, but are a direct result of the impoverished conditions in which people live.

"They love their children," she said, "but if you see how they live — we're talking about Third World conditions right here in Alabama."

The answer, she said, lies in a better system of socialized medicine coupled with improved education and economic stimulation.

"If people had the opportunity to earn a decent income, they wouldn't be in this condition," Cook said. "Nobody likes to live this way. They need job training and jobs. That would do a lot for infant mortality."

Nettles believes hope lies in an overhaul of the social welfare system.

"It lies in marriage and having somebody else be the breadwinner of the family other than the mother," he said.

Though some might find Nettles' proposed solutions radical, he believes them eminently sensible.

The government should subsidize young people who marry and require that all those not married who are having children attend prenatal care classes and even pay a tax for each child born out of wedlock, Nettles said.

But whatever solution is tried, until some sort of change in the current social system is instituted, babies will keep dying, and Wilcox County will likely continue to cringe under the stigma of having the highest infant mortality rate in Alabama.

"And so the cycle continues," Cook said. "You just look at these youngsters teeming with life and you know the life they're going to have."

Mother struggles against poverty, dreams of better life

By Susan Eggering
Journal staff writer

PINE APPLE — There seems to be no question that there is a direct link between infant mortality and poverty. Studies prove it. But better yet, ask Dr. Roseanne Cook.

"(Poor) nutrition and housing are two big, big factors that contribute to infant mortality," the Wilcox County physician said.

Cook knows. During the course of her rural house calls, she sees the horrendous living conditions of some area residents.

She sees shacks crammed with beds, cardboard used to patch together crumbling walls and mothers struggling to care for their young the best they can. Mothers like Martha Hamilton.

Martha, 28, is all too familiar with poor housing, sickness and the ultimate sadness of losing a child.

It was in November some years back, and Martha was pregnant. She needed fuel to stoke her meager wood-burning stove, the only source of heat for her four-room shack. So as she always did, she went outside and began chopping.

"I had pain," she said, "and I felt somethin' comin'."

Then it was over. She miscarried. What would have been her firstborn child was dead.

When she finally went to the doctor several days later, he asked her what she'd been doing. The strain of chopping and hauling wood likely was responsible for her pregnancy's termination, he said.

Life's improved somewhat for Martha in the intervening years. She's had three children, each of whom mirrors her soft, dark eyes and warm, shy smile. But her living conditions haven't changed.

Home for the Hamiltons is still a shack on a patch of dirt outside the town of Pine Apple in Wilcox County. A dust-covered rock serves as a step to the sagging porch where dilapidated floorboards nearly break even when children walk on them.

There is no screen on the front room's only window, and sagging wooden shutters are thrown wide, letting in the summer heat and mosquitoes. There is no running water.

There is not even a fan to stir the stagnant air. After dark, the room's sole illumination is a single, 25-watt light bulb which hangs naked from a nest of exposed wires on the ceiling.

The shanty is stifling in summer, frigid in winter. Martha has to be especially careful that her kids don't take sick. Two of them have sickle-cell anemia, and the third carries the trait.

Her little boy, Leroy Jr., suffers from severe bouts of pain from time to time.

"(Then) he can't walk, he can't eat, and he cries a lot," Martha said.

Her youngest, born with six fingers on each hand and six toes on each foot, scoots around the cabin with her small legs and feet bandaged in gauze booties, a remnant of corrective surgery.

In an attempt to improve the flooring, Martha has laid down a piece of linoleum.

"You gotta pay a lot of attention to 'em when you don't got no running water," she said. "The house we stay in, they catch a lot of colds."

When it rains, the rusted tin roof leaks so badly that mother and children take refuge a mile and a half down the dirt road at the home of Martha's mother.

"When it rains, you can take a bath in it," Martha said. "There ain't nothin' you can do."

Even on the best of days, life in the ill-equipped shack is no picnic. There is no phone, no working stove, no bathroom, no outhouse. She prepares the family's meals on a hot plate or in her toaster oven and, in the morning and evening, totes jugs of water to the house.

Things are never easy.

The family's only luxuries, a tape player and a television, were stolen this year, along with some of the food Martha had stored in her deep freezer. The freezer is a necessity rather than an extravagance since she does not drive and only gets to town two or three times a month to do her shopping for food.

Life is frustrating for Martha who, like mothers universally, wants the best for her children — Miesha, 5, Leroy Jr., nearly 3, and Shekita, 2. She longs for the day when, somehow, that might be possible.

Now it is not. Now all she can do is provide them with food and shelter of the most primitive sort.

Her dream is to one day live in a mobile home where each of her children can have a room to call his own. Where they live now, the family shares a single crowded bedroom. She worries that her children will not want to bring playmates home once they start to school out of fear they will be laughed at for being poor.

"When people come around, you be easily embarrassed," she said.

She has done her best to better [illegible] family's situation. She's looked for jobs in Camden, Selma and Montgomery, but there are none to be had. She's tried to find a better house. One time when she did, the owner said it wasn't for rent, although he leased it to someone else shortly thereafter.

Martha gets discouraged from time to time. "I'm tired of raisin' my children here," she said.

But she is a strong woman who is far from ready to give up. Her stamina to weather the worst is one of her greatest strengths. It lets her hold tightly to her dream of a better life.

"I just gotta push a little harder for it," she said.

Teen pregnancy, infant mortality rates go hand-in-hand

By Emily Bentley
Journal staff writer

Of the 788 babies under age 1 who died in Alabama last year, one-fourth were born to teen-age mothers.

According to experts like State Health Officer Earl Fox, Alabama's high teen-age pregnancy rate goes hand-in-hand with the state's high rate of infant mortality.

A teen-age pregnancy is a set-up for low-weight birth and other complications and, therefore, for infant death.

While babies born to teen moms made up only 17.4 percent of the state's deliveries in 1986, they accounted for 25 percent of the infant deaths, according to figures from the state Bureau of Vital Statistics.

In 1985, Alabama's overall infant mortality rate for babies of mothers of all ages was 12.6 per 1,000, while babies of teen-age mothers — looked at alone — had a mortality rate of 18.7 per 1,000.

Doris Barnette, head of the state Department of Public Health's Division of Family Health Services, said addressing the number of teen-age pregnancies would help solve the infant mortality problem.

In Alabama in 1986, 788 babies died before their first birthday; 199 of those were the children of teen-age mothers, according to Department of Public Health records.

The 1984 figures — the latest national comparisons available — show Alabama ranked fourth among states in the number of teen-agers giving birth.

According to 1986 figures, Alabama is first among states in infant death.

But Fox said while a teen-age mother is at an increased risk of delivering a low-birth-weight baby and of having other complications, the consequences of teen-age birth can be almost neutralized through proper prenatal care and education.

Fox said the incidence of teen-age pregnancy has decreased in the past few years. State Bureau of Vital Statistics records show Alabama's teen pregnancy rate declined from 18.2 in 1984 to 17.4 in 1986.

"I think that's evidence that you can make a difference," Fox said.

Those who do get pregnant are faced with a family of their own when they should be concerned with school, friends and their parents and siblings.

Barnette said because a teen-ager's body is not fully mature, pregnancy for teens is more risky than for slightly older women.

"Teen-age mothers are more likely to deliver low-birth-weight babies," Fox said.

Also, teen-agers tend to deny — even to themselves — that they could be pregnant. They put off finding out for sure, and they delay seeking medical care or alternatives, such as adoption or abortion, to keeping the baby.

> While a teen-age mother is at an increased risk of delivering a low-birth-weight baby and of having other complications, the consequences of teen-age birth can be almost neutralized through proper prenatal care and education.
>
> *Earl Fox, state health officer*

The lack of accessibility to medical care that plagues many women — 26 counties in Alabama have no obstetric services — puts hurdles in front of even well-intentioned young women who know they should see a doctor.

If the baby's father is not around and the family is not willing or able to provide transportation, a one- or two-hour trip to a city for a doctor's visit can be inconvenient or impossible.

And that is if the teen-ager has the money or insurance to convince a doctor to see her. She may not know of locally offered prenatal education classes or pregnancy screenings or she may shy away from them to avoid exposing her pregnancy to local people.

A pregnancy is not the ideal news to bring home to parents. Often because of social or familial pressure, young mothers-to-be find themselves on their own, probably for the first time in their lives, without experience in taking care of their own needs.

Even for teen-agers who are in a better home situation, poor nutrition plays a big part in the poor start a baby born to a teen-ager often gets, Barnette said.

Teen-agers frequently do not recognize the need for a balanced diet and the need to stay away from substances like alcohol, tobacco and caffeine during pregnancy.

A female teen-ager often does not take good care of herself, much less an infant growing inside her, said Fox.

Ted Williams, chairman of the Alabama chapter of the American Academy of Pediatrics, said even teen-agers' babies who are delivered without serious complications often develop nutrition-related problems after they are taken home.

"A woman leaves the hospital with the baby, and it may be a poor feeder," Williams said. "The mother is most likely under 21."

In addition, because of the new pressures of motherhood and the immaturity of teen-agers, child abuse is a greater danger for the baby of a teen mother.

To a woman who is herself still a child, the round-the-clock responsibility of caring for an infant can be overwhelming, experts say.

Fox said through educating young mothers on how to care for themselves and their babies, the tendency toward child neglect and abuse — and more unwanted pregnancies — can be diminished.

"We can almost neutralize the effects of teen pregnancy with prenatal care and reduce the risks — if we get them into the (health care) system," Fox said.

1986 teen pregnancy rates by county

HIGHEST

COUNTY	BIRTHS TO TEEN-AGERS	PERCENTAGE OF TOTAL BIRTHS
Sumter	85	27.3
Butler	91	26.7
Macon	103	25.9
Conecuh	54	25.8
Talladega	281	25.4
Lawrence	98	24.6
Pike	98	24.4
Chambers	117	23.9
Choctaw	57	23.8
Bullock	45	23.6

LOWEST

COUNTY	BIRTHS TO TEEN-AGERS	PERCENTAGE OF TOTAL BIRTHS
Shelby	130	9.8
Dale	112	12.2
Madison	437	12.9
Montgomery	501	14.6
Coffee	90	14.7
Morgan	197	14.7
Jefferson	1499	15.2
St. Clair	94	15.4
Baldwin	206	15.5
Hale	41	15.5

Source: The Bureau of Vital Statistics of the Alabama Department of Public Health

Journal graphic by Phyllis Perry

PORTRAIT OF A HIGH-RISK INFANT

PRENATAL CONDITIONS

- **Race.** The infant death rate for blacks is almost twice the rate for whites.
- **Age.** Women younger than 17 or older than 35 are more likely to lose babies.
- **Poverty.** Babies born to poor women are at a higher risk.
- **Number of births.** A woman who has never had a baby, or one who has had more than four children, is considered high-risk.
- **Weight.** An underweight mother is more likely to have an underweight baby. A mother who was a premature infant or weighed less than 5 pounds, 5 ounces at birth falls in the high-risk category.
- **Disease.** Diabetes or chronic hypertension contributes to the risk factor.
- **Obstetrical history.** A mother who already has had a low-birth-weight baby or more than one spontaneous abortion is considered high risk.
- **Complications during pregnancy.** Bleeding, cervical problems, etc., contribute to the risk factor.
- **Health.** Smoking, poor nutrition and alcohol and drug abuse by the mother all are dangerous to the health of the unborn child.

DELIVERY CONDITIONS

- **Birth trauma.** Experts say treating a patient in labor who has no prenatal record is the highest of risk factors. The delivering physician has no way of knowing what prenatal conditions are involved.

POSTNATAL CONDITIONS

- **Abnormalities.** Heart and respiratory problems are most common in premature newborns.
- **Poor living conditions.** The environment to which the newborn goes home is important.
- **Health care.** Poor child care, lack of immunizations, nutrition, etc. contribute to the risk factor.

A Death In The Family

Politics, high costs spell doom for some of Alabama's babies

By Frank Bass
Journal staff writer

Alabama babies have been dying for a long time.

For decades, the death of children during their first year of life has been nothing more than something to attribute to fate.

But earlier this year when it was revealed that Alabama had the highest infant mortality rate of any state in the nation, it wasn't so easy to dismiss the problem as a simple matter of fate.

It's a well-established fact that infant mortality can be curtailed by providing access to prenatal care for mothers.

Access to prenatal care, according to experts, prevents low birth weight, which in turn lowers infant mortality.

And providing access to prenatal care should be simple.

But it's not.

Why?

"I don't think it's resistance," said Doris Barnette, head of the Alabama Department of Public Health's Division of Family Health Services. "I think it's [illegible]."

The failure of Alabama to take action on a problem is not without precedent.

Efforts to solve similar social problems, like teen pregnancy, poverty or racism, have met the same resistance. Time after time, the attempts have been thwarted.

Part of that inertia must be attributed to the costs inherent in solving any social problem.

More likely than not, mothers of dead children are black, poor and ill-educated. So the issue of infant mortality has not always been a burning one in a predominantly white, conservative state. The issue is further removed from the mainstream when a dead baby is perceived to be someone else's problem.

"There are no lobbyists for children," said Rae Grad, executive director of the National Commission to Prevent Infant Mortality. "So this one has to come from the heart or the pocketbook."

However, none of these factors alone — the costs, politics or isolation — has placed Alabama in the shameful position of losing 788 infants last year and having the highest infant death rate among the 50 states.

What has given Alabama a high infant mortality rate, most experts agree, is a lack of education — or, put less politely, ignorance.

"Education and infant mortality go hand-in-hand," said Barnette.

This lack of education has manifested itself in many ways. Since most teen-agers do not know enough about their bodies, they become pregnant. And since teens do not know enough about their bodies or their babies, children die.

The state has given some pregnant mothers — those whose incomes are 16 percent of the federal poverty level — the opportunity to have people take care of them and their babies.

Ironically, it's been shown that the costs of ignoring infant mortality are higher than the costs of reducing it.

Yet, according to Tommy McDougal, director of the Alabama Hospital Association, "We've sort of had the mentality in this state to hold the line and not spend any more dollars."

Dale Quinney of the Alabama Department of Public Health's Bureau of Vital Statistics agreed. "Traditionally, we've kind of lived off the milk of the federal government in this area," he said. "Now, that revenue is being withdrawn, and Alabama is really feeling it."

Many of the politicians in Alabama are elected on a platform of reducing taxes and continuing services. The short-term benefits of that political strategy are clear. But the long-term ramifications often are not examined by an electorate placing style over substance.

The apathy preventing Alabama from reducing infant mortality also may be attributed to the nature of the tragedy. Dead children do not vote, and the parents of dead children seldom are willing to bare their pain for the rest of the world to see.

But access to prenatal care in Alabama is hardly universal. In 36 of Alabama's 67 counties, no obstetric care is available. Most attribute the lack of obstetric care to greedy insurance companies, litigation-happy lawyers or incompetent physicians.

In the counties where such care can be found, the people who need it the most often don't know how to manipulate the health care system to their advantage.

The recriminations continue. Some have charged the Alabama Medicaid program is inadequate, the state Department of Public Health's budget is a shambles, the legislators are timid, the lawyers are conspiring to run the physicians out of business, and the insurance companies, charging high rates for liability coverage and health insurance, are going to slay everyone.

But in the meantime, small children, who have no comprehension of the arguments being advanced, are dying. Their parents, who often have no understanding of the machinations used to deny their children health care, are grieving.

And almost everyone continues to ask, "Why?"

1 angry physician calls it quits

By Peggy Roberts
Journal staff writer

Dr. Felix Tankersley was in the shower just before 7 a.m. when the emergency room doctor at Jackson Hospital called to say a walk-in patient was ready to have her baby.

Being the obstetrician on call, Tankersley left the house without shaving and hurried to the maternity ward, where he delivered 27-year-old Valisha Jones' third baby.

Since it was to be his next-to-last rotation as an obstetrician in Montgomery, the doctor was hoping for a slow day that sweltering morning in late July.

But before he had finished his 24-hour shift, six pregnant women he had never seen before needed his attention.

"That's the reason I'm quitting," he said. "You just never know what you're going to be facing, and there's no way to avoid being on that rotation."

Before the end of this year, there may be as few as 10 obstetricians still delivering babies in Montgomery.

In the last few months, at least two have left, and several others are considering quitting.

Tankersley and other local obstetricians are angry about the deteriorating conditions in the Montgomery emergency room rotation.

They argue the system encourages indigent patients to neglect prenatal care by allowing them to drop into the emergency room when they go into labor.

In an emergency room, a certified obstetrician is obliged by law to deliver their babies.

And what the doctor on call faces is a threat to both the mother's and the infant's health and to his own legal security.

"I want someone to know what kind of horror I'm facing," said Tankersley after his 24-hour shift was over.

Three of the patients Tankersley cared for on that shift delivered healthy babies.

Two of them, including a 28-year-old who on that day had her sixth child, he offered to sterilize.

"I told them I'd tie their tubes for nothing.

"People might criticize that, but you can't tell me it's not easier to feed three or six than 12," he said.

The mother of six accepted Tankersley's offer and had the procedure done after she delivered. The other woman opted not to have her tubes tied.

"My husband said he might want more," she explained. "No time soon, though."

A 22-year-old unmarried Prattville woman, arriving at the emergency room in mid-afternoon, miscarried in her fourth month of pregnancy.

And a 16-year-old girl who checked in bleeding at about 4:30 p.m. delivered a 2-pound infant who died shortly afterward.

"I had no way of knowing how long she was bleeding," Tankersley said. "She was infected, too, and I don't know how long she had been that way."

His most serious case that day was a 20-year-old woman, bleeding and in labor, who hadn't seen a doctor since she delivered her third child last October.

"I saw her about 12 times over a three-day period, and during that time, her bleeding got worse, so I sent her over to Baptist (Medical Center) to the neonatal unit, where I did a C-section on her," Tankersley said.

The 3-pound baby boy lived through the birth, and the doctor said his chances of survival would double each day. "But there will be a $150,000 medical bill," he said, referring to the hospital charges for intensive care the baby will need.

The woman had no health insurance of her own and wasn't covered under Medicaid.

Only one of the six patients had private insurance, but the 17-year-old mother who had insurance coverage didn't seek the care of a private doctor before delivery.

Tankersley said the girl's mother is a maid at a medical office building, and he's known her for years. "She has insurance, and yet she let her daughter get her care from the county clinic," he said.

When asked why she didn't take her daughter to see Tankersley, the woman just shrugged.

Tankersley did his last emergency room rotation July 12 and delivered his last private patient at the end of July. He will allow his obstetrical malpractice insurance to lapse. He'll still see patients for gynecological services.

One patient he cared for through two pregnancies sat in his office with her husband and cried when the doctor told her he wouldn't be delivering her third child.

"I understand what you're up against, but what's going to happen when there's nobody left?" she asked.

"I really feel for them, and I'd like to keep delivering babies, but I can't afford to do it the way

(Please see QUITS, Page 11)

Quits

they've got it now," he said.

Tankersley has long been a vocal critic of the Medicaid system.

He charges that public funds are being misspent. "If you ask them (the state health department) for a breakdown of how every penny of that money is spent, you'll find out that it's costing more to provide poor obstetrical care through the clinics and the emergency room than through private doctors," he said.

Tankersley would rather see the funds that are currently spent on Medicaid diverted into the private sector. He suggested a pilot project in which private obstetricians would provide total care for women throughout their pregnancies.

"I've been criticized for my views because they've said I have a vested interest in this," he said. "But now I won't because I won't be delivering babies, and I still feel the same way."

In an effort to avoid being included in the emergency room rotation, Tankersley and two other local obstetricians offered to take on six patients per month — the average number of walk-in patients whose babies he delivered prior to quitting. They would have become his private-care patients.

But most of the other obstetricians in town opposed the idea because it would have meant fewer doctors on the rotation, and each one's turn would have come around every 12 days instead of every 15.

That was the only way Tankersley would stay in obstetrics — if he could deliver only the babies of mothers he had provided total prenatal care from the outset.

To best describe his feelings of frustration over being forced to deliver babies of women he had never seen before, he told the story of a woman who walked into the Jackson Hospital emergency room on Thanksgiving Day two years ago.

The indigent patient's doctor had sent her from Troy to a Montgomery hospital, where an obstetrician was sure to be on call. "She wasn't too far along in her labor, and I didn't want to be responsible for delivering another one I had never seen before, so I told her to go back to Troy," said Tankersley.

"She said, 'I'm going to have my baby right here, and you're going to deliver it, or I'm going to sue you.' She knew she had me. And I delivered that baby," he said.

Tankersley sat back in his chair and shook his head. "It's not a question of money, really. It's just too much of a risk going in there and not knowing what kind of situation I might have to face that day."

Health experts say Medicaid woes contribute to infant mortality rate

By Peggy Roberts
Journal staff writer

Sixteen-year-old Terri's voice shook as she described her ordeal since she discovered she was pregnant three months ago.

"I'm overjoyed about it," she said, obviously more sadly determined than happy. "Maybe it'll change me. I was bad."

A diminutive girl dressed in a Montgomery high school drill team sweatshirt with her nickname spelled out in iron-on letters on her back, Terri is facing more exasperating problems than the average pregnant teen-ager.

When she applied for Medicaid to cover her prenatal care and delivery, Terri, not her real name, first was told she didn't qualify. Although her mother, a single parent, has no work income, she wasn't eligible because her younger sister collects Social Security benefits.

Even when she finally got Medicaid, she couldn't find a doctor in Montgomery who would take her as a patient.

Medicaid in this state pays $450 to deliver a baby. That includes six prenatal care visits and the doctor's expenses in delivering the child.

Doctors receive an average of $2,000 for a delivery paid for by the patient or by private insurance.

And with the number of delivering obstetricians in Alabama dwindling, it is getting tougher to find a doctor who'll accept the minimal Medicaid payments.

Health experts are worried the Alabama Medicaid system is part of the reason infant mortality in the state is so high.

'The system is working for those who are eligible and receive the benefits. Medicaid has had some impact, and it has been positive.'

Faye Baggiano
former Medicaid commissioner

Each year in Alabama, teenagers like Terri fail to receive proper prenatal care and lose their babies before the infants reach age 1.

The Medicaid system is fast becoming one of the most hotly debated issues in the state. Experts can't agree whether Medicaid reform is the answer to reducing the state's high infant mortality rate, but they do agree the system needs changing.

Terri was disgusted and confused over her predicament. "I called every one of those doctors on the list they gave me, but nobody would take me," she said, choking on her words.

She doesn't know if the obstetricians she called turned her down because she was too far along in her pregnancy (most doctors won't take new patients after they reach their fifth month) or because there are now too few local obstetricians to care for the private patients who are willing to pay the entire fee.

She will continue to attend the Montgomery County Family Health Clinic, where she waits with 45 other women to see a volunteer doctor for a few moments. When she goes into labor, she'll go to the emergency room and be delivered by an obstetrician who knows neither her nor her medical history.

"The Medicaid system isn't helping many of those most in need," said Dr. Earl Fox, the state's health officer. "The public doesn't appreciate the importance of Medicaid in health care."

One option to expand Medicaid currently being considered in the Legislature is participation in a federal program that would match three-to-one funds raised on the state level for the care of mothers and children.

Known as the Sixth Omnibus Budget Reconciliation Act, or SOBRA, it has gained strong support among Alabama's physicians. It would allow pregnant women who earn more than the $1,416 annual limit allowed under the current Medicaid system to get medical benefits during their pregnancies and for the first year of the baby's life.

To be eligible for Medicaid benefits in Alabama, a candidate must earn less than $118 a month, or 16 percent of the poverty level as set

'The Medicaid system isn't helping many of those most in need. The public doesn't appreciate the importance of Medicaid in health care.'

Earl Fox,
state health officer

U.S. Medicaid eligibility levels for 1985*

STATE OR TERRITORY	RANK	MONTHLY ELIGIBILITY LEVEL	PERCENTAGE OF POVERTY LEVEL
Puerto Rico	1	$80	11
Alabama	2	$118	16
Tennessee	3	$153	21
Guam	4	$165	22
Virgin Islands	5	$171	23
Texas	6	$184	25
Louisiana	7	$190	26
Arkansas	8	$192	26
Kentucky	9	$197	27
Georgia	10	$232	30
Arizona	11	$233	32
Florida	12	$240	33
N. Carolina	13	$246	33
W. Virginia	14	$249	34
Indiana	15	$256	35
New Mexico	16	$258	35
Missouri	17	$274	37
Nevada	18	$285	39
Mississippi	19	$286	39
Ohio	20	$290	39
Virginia	21	$291	39
Oklahoma	22	$292	40
Delaware	23	$298	40
Idaho	24	$304	41
Wash., D.C.	25	$327	44

*1985 federal poverty guidelines: $8,850 for a family of three

Journal graphic by Phyllis Perry

by the federal government.

And even those pregnant, indigent women who are eligible under the current system often fall through the cracks.

Nineteen-year-old Debbie Edwards earned $75 a week as a waitress at a local restaurant until she got too far along in her pregnancy to work. She had no health insurance, and although she took a leave of absence from her job, she isn't sure the job will still be open when she is ready to go back to work.

But she was ruled ineligible for Medicaid.

"I was four months along before I even knew I was pregnant," she said. She is healthy and is receiving some prenatal care at the Montgomery County Family Health Clinic, and when she is ready to have her baby, she'll have to go to the emergency room to deliver.

When the baby arrives, she plans to take on two jobs to pay her hospital bills.

Debbie probably would have gotten Medicaid coverage, if she'd simply said she wasn't working.

"You have to know how the system works to make it work for you," remarked another woman at the Montgomery County clinic.

The unemployed aren't the only ones passed over when the Medicaid money is doled out.

Faye and Randy Ford, a Chisholm couple, had their third baby in mid-December, just 10 months after their second child was born.

Brittany arrived early.

"Some people say she might have been premature because she was so soon after Taylor Michelle, but the doctor didn't say for sure," Faye explained.

(Please see MEDICAID Page 12)

Medicaid

The new baby didn't have extensive complications, but she was just small and weak enough to require hospitalization for the first three weeks of her life.

When the Fords took their baby daughter home, they also took home a bill for $15,000.

Neither Randy's job as a welder nor Faye's job in a Montgomery factory offered health insurance benefits, and Faye said they don't earn enough to purchase a private insurance policy.

"We had enough money saved to cover the cost of a regular delivery," she said.

Now they're hoping to work out a monthly payment schedule that will allow them to pay their medical bills little by little, without devouring their total income. But it will take years.

Former Medicaid Commissioner Faye Baggiano, who is writing her doctoral dissertation on the relationship between Medicaid and infant mortality in Alabama, agreed.

"The system is working for those who are eligible and receive the benefits," she said. "Medicaid has had some impact, and it has been positive."

Critics find little merit in the current system.

"It pays less than in any other state in the country," said Dr. Robert Beshear, a Montgomery pediatrician who has been active in trying to draw lawmakers' attention to the state's infant mortality problem.

"It actually penalizes a poor family in which the parents are making an effort but maybe only earning a minimum wage and receiving no health benefits," he continued. "It seems to me that a system where a family who earns more than $118 per month can't get assistance is tragic."

Beshear is especially critical of state officials who haven't made better mother and child health care in Alabama a top priority. "They have no long-term vision when they say we don't need money for these programs," he said. "It's a great silent tragedy."

Vicious cycle of high death rates can be broken, experts say

By Emily Bentley and Frank Bass
[illegible]

Alabama's high infant mortality rate is part of a vicious cycle that robs children of life.

But health experts say the cycle can be broken by getting proper prenatal, or before delivery, care for women who haven't been getting it.

In Alabama in 1985, there were 59,663 births — 999 to women who received no prenatal care. About 6,000 of the women received inadequate prenatal care.

Statistics show that the rate of infant death is five times greater among babies born to mothers who have not had at least four medical checkups during pregnancy.

According to health officials and doctors, the way to begin tackling Alabama's number-one-among-the-states infant mortality rate is to make prenatal care and delivery services more readily available.

Ted Williams, a Dothan pediatrician and president of the Alabama chapter of the American Academy of Pediatricians, said Alabama's prenatal care and infant mortality problems will only worsen unless care is made more accessible.

"A significant number of those bad outcomes could be prevented with good prenatal care," Williams said.

"We don't have to have an obstetrician in every hamlet, but we do need to have prenatal care available," he said.

Rural and poor areas offer the least opportunities for prenatal care.

Williams said if mothers-to-be get adequate prenatal care, the rest of the solution to the infant mortality problem will fall into place.

Top priority — by consensus — should be to expand Medicaid eligibility.

State Health Officer Earl Fox said the state's Medicaid eligibility standard — 16 percent of the federal poverty level — encourages a cycle of infant mortality.

The cycle involves mothers-to-be who have had little or no prenatal care going to a hospital or doctor for delivery. Because of the increased risk associated with lack of prenatal care, doctors face increased liability risk and the possibility they'll have to foot indigents' bills.

Because of the risk and cost, doctors stop delivering babies, and that only decreases the availability of care and increases the chances of bad pregnancy outcomes for women and the burden on doctors who continue to deliver.

"What we need is to maximize Medicaid and have some money available for non-Medicaid eligibles," Fox said.

Medicaid eligibility traditionally has been contingent on eligibility for Aid to Dependent Children, welfare money available to single mothers and their children.

The problem with that, however, is it eliminates many married women from Medicaid coverage.

Through a federal Medicaid expansion program called SOBRA, which stands for Sixth Omnibus Budget Reconciliation Act, Medicaid eligibility no longer is tied to welfare eligibility.

Fox said Medicaid expansion is the answer, with 73 cents in federal money for every 27 cents the state spends.

Doris Barnette, head of the state Department of Public Health's family health services division, agreed.

A pregnant woman in Alabama whose family income is more than 16 percent of the federal poverty level currently is not eligible for Medicaid.

In Alabama, that means a three-person family can earn no more than $1,416 annually.

The state's Medicaid eligibility standard is the lowest in the nation.

For those mothers eligible for Medicaid, there is little doubt the program works. The infant mortality rate in 1986 for babies of mothers on Medicaid was only 10 deaths per 1,000 live births.

If the state can pull together $8 million, matching funds from the SOBRA can be used to triple the investment to about $24 million for expanding Medicaid coverage.

The matching funds would enable about 10,000 mothers who earn as much as 100 percent of the federal poverty level to be brought into the Medicaid program if the state matched the federal funds.

The money would ensure health care for women and their children younger than a year old. The money also would be used to increase nurse-midwife and obstetrician fees.

By gaining access to those medical visits, women also would be exposed to education and family planning information, Fox said.

Medicaid Commissioner Mike Horsley has proposed legislation to help get a continuous funding source for the state money needed to get the federal match.

"I can't expand a program without assuring continuous funding, and we just don't think the money is available through the General Fund," he said.

Horsley said he and Gov. Guy Hunt developed the plan to pool indigent care funds from local governments through creation of the Mothers and Babies Indigent Care Trust Fund. The plan was approved by the Legislature this year.

The local money will be channeled through the fund to obtain the federal matching funds, Horsley said.

Legislators also this year appropriated $1 million to go toward implementation of SOBRA.

Fox said in his department, money is needed to hire doctors and to provide education. Women who do not get perinatal education sometimes do not know how to care for themselves or their babies.

[illegible]

A mother's lament

Family loses child after 10-week fight

Sharon and Melvin Ramsey of Camden have a new, healthy baby boy. But the memory of another little boy's death stays with them.

Sharon gave birth to Melvin Douglas Ramsey Jr. on April 27, 1986. A worker in a sewing factory before her pregnancy, Sharon had received good prenatal care. But her baby had internal problems.

During his short life, the baby was in and out of hospitals. He lived approximately 10 weeks.

He was one of 788 Alabama babies who died last year before his first birthday.

Earlier this year, news that Alabama and Wilcox County have high infant mortality rates prompted Melvin Ramsey, an officer with the state Department of Corrections, to write a letter to the editor of his local newspaper. While noting that his son received good medical care, Ramsey noted other babies weren't so fortunate. He decried the failure of Alabamians to tackle the infant mortality problem, especially as it affects poor, black, teen mothers.

Now, in her own words, Sharon, 27, tells the story of the baby the couple lost.

He shouldn't have been breathing so fast. I discovered it myself. I was giving him a bottle.

See, when he came home from the hospital, the doctors said he was normal. But he never (threw up) like babies are supposed to. He gagged it up, and he'd kind of turn purple.

I told my husband, but he said, "All babies do that." But he doesn't know. They don't.

"I've got to take him to the doctor," I said.

He was two weeks old.

We took little Melvin to the clinic, but the doctor said he was all right. They thought it was the milk. They just changed his formula.

I turned right around and took him back Friday — two days later — because he was still doing the same thing. I told them, "Look how he's breathing."

He started gagging in the doctor's office, and I told a nurse, "Please come here and look."

It wasn't like when babies (throw up). It would take his breath away, and his lips would get so dark.

They said for us to take him to the Children's Clinic in Selma. They told us they didn't know what was wrong. They said they wanted to do some tests on his heart and lungs.

The doctor asked us if we had transportation. They said they would send a helicopter if we didn't. I was thinking by that time that it must be serious.

That was the only son I had, and I wanted to keep him. They said for us to take him to the children's emergency room.

He had so many doctors, I couldn't name them. But they still didn't tell me what was wrong. They said, "We're going to run some tests."

They began to show me his heart, what he looked like inside — his right side that never did develop, that was twisted back in him. I never knew what was wrong. I asked the doctor, and he said it was his heart — and several other things.

I cried and cried. The doctor wouldn't tell me no more 'cause I was hollering so.

He talked to my husband from then on because he was a little stronger about it.

From there, they took him to Birmingham. That was a Sunday they transferred him to University (Hospital). They put a pin in his hip that ran all the way up to his heart. He was just going to have stitches on the sides of his legs from the surgery.

After the surgery, we brought him home for a month. We took him back for his checkup in Birmingham on June 13. That was a Friday.

"Mrs. Ramsey, he has gotten worse," the doctor said. "We're going to have to go into his heart."

They had given me a room at the hospital when I was up there with him before. But they said they couldn't let me stay all that time. We stayed with my brother that weekend, and the social worker found a place for us near there (the hospital).

They were going to do surgery Tuesday. They were going to have to open up his heart and clamp his valve.

"What is his chance of living?" I asked.

The doctor said 25 percent. I prayed, and I asked the church to pray for me.

When we took him back to University, they put him in the nursery. They said he was sick and we couldn't see him.

But he was so good. They don't holler much, babies born with heart problems, the doctors said.

So many people just fell in love with "that little Ramsey baby."

He had so many tubes in him.

Come July 10, he died — at 6:15 in the morning.

They had opened him up three or four more times after surgery. They took him back in because he started bleeding inside.

You don't know what it's like 'til you go through it. You never thought it would happen to you. How it happened is a question they haven't answered yet.

I don't smoke, I don't drink. During pregnancy I was careful to eat right. But they said that doesn't matter. It just happens when they develop.

But it took something out of me. It was hard to see the mothers that I got acquainted with — to see their children go home, and mine didn't.

My baby came out of ICU (the intensive care unit) three times, and they had to take him back.

A day doesn't go by that I don't think about him. We go to the graveyard often. His grave's got a headstone.

I wanted to know what would be the chance that would happen again if I got pregnant. I thought it came from my history, but they said it didn't. The doctor said it was likely it might never happen again.

I had another boy May 31. That's Brian O'Neal (Ramsey).

But on June 13, my husband said, "Remember, this was when we took little Melvin back to Birmingham."

I did remember.

Journal staff writer Emily Bentley compiled this story.

Premiums force some hospitals to quit baby business

By Peggy Roberts
and Emily Bentley
Journal staff writers

Teen-ager Martha Kelly was at a friend's house watching television on a miserable, rainy night last March when she heard the whine of an ambulance siren. From the sound, she could tell the ambulance had stopped just down the road.

Curious, she and her friend pulled on their raincoats and went outside to investigate.

As she drew close to the scene of a two-car accident, Martha saw through the darkness and rain that one of the cars belonged to her mother.

"That's how I knew," the teenager said, quietly staring at the carpet in her Eufaula living room.

The mother had been rushing Martha's pregnant sister, April, age 15, to the hospital when the car collided head-on with another car en route to a different hospital.

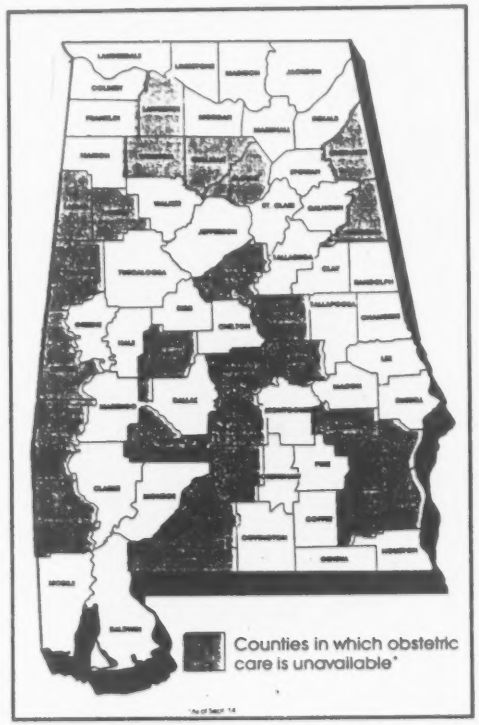
Both April, who went into early labor in her sixth month, and her baby boy, delivered by Caesarean section after the accident, died from their injuries.

While they lived only a few miles from Lakeview Community Hospital in Eufaula, the family had known all along that April would have to be taken 60 miles to Troy for the birth of her baby.

The reason: Lakeview had stopped delivering babies 18 months earlier after malpractice insurance became too expensive.

"If that hospital had taken babies, we wouldn't have had to leave," said the mother, also named Martha Kelly.

The high cost of malpractice liability insurance has made it financially impractical for many doctors and hospitals to deliver babies, medical officials say.



While some rural counties have never had obstetric services, 26 of Alabama's 67 counties now are without them. That means women in those 26 counties must go to urban centers for care — or do without care.

The counties without delivery services have a total population of about 450,000.

As the number of Alabama hospitals that deliver babies continues to dwindle, more of the state's rural residents have to travel long distances under extreme emotional stress.

Getting transportation to a doctor for prenatal care and for delivery is difficult for patients, especially indigent ones.

The lack of delivery services means women whose pregnancies are high risk face an every higher risk.

"What we're doing now is about the highest risk you could have," said Earl Fox, state health officer.

Beshear

Robert Beshear, a spokesman for the Alabama chapter of the American Academy of Pediatrics, said something has to be done to bring pregnant women adequate care and to stop doctors from going out of business, or the situation will only get worse.

"We deal with it every day, and we see babies die. We see infants dying needlessly from a lack of care. And that, by a large part, is preventable," Beshear said.

With fewer doctors delivering, the burden increases on those who continue to deliver.

Prodded by doctors and business organizations, the Legislature this year passed a package of bills changing the state's civil liability laws. It's called tort reform.

Outrageously large court awards in recent years have driven liability insurance rates skyward, proponents of the legislation argued.

Tort reform legislation is designed to cut insurance companies' risk in offering affordable liability insurance by limiting certain types of damages and establishing more stringent criteria for lawsuits to be filed.

But doctors and others say tort reform is not enough, and it will not have an immediate effect on rates or availability of insurance. It will take several years for insurance rates to reflect the reduced risk factor, they say.

In the meantime, more doctors stop delivering babies, and more babies die.

And hospitals feel the pressure. At Lakeview, where some 300 babies used to be delivered annually, the hospital couldn't justify the high cost of liability insurance after its local licensed general practitioners cancelled their obstetric insurance.

"It wasn't worth it to the previous owner to pay those rates when so few babies would be delivered here each year," said Roger Glass, the hospital's administrator.

The hospital's new owner, HealthCorp. Inc., based in Nashville, Tenn., is planning to start delivering babies again, but Glass knows it will be costly.

"Everybody expects to bring home a Gerber baby, and if they don't get it, things happen," he said, referring to malpractice suits.

If the company elects to continue the hospital's delivery services, Glass insists it will not be open to walk-in patients.

"The women will be required to participate in the educational programs we provide. They will have to have prenatal care," he stressed.

Glass isn't contemplating starting up the service again because he is a good Samaritan, he admitted.

"We have a 15 to 20 percent occupancy rate right now," he explained. "And having a baby is about the only happy time a person comes to the hospital. Delivering babies is good public relations."

Cycle

In 26 of the state's 67 counties, no obstetrical services are available, so public health is being forced to shoulder much of the burden of providing prenatal care.

"We need medical manpower sufficient to serve the state of Alabama," said Barnette. "We are facing some dire situations up in the northern part of the state. We're hoping they'll hang on."

Fox said he eventually hopes to have one health department physician for every three counties and a nurse practitioner in every county.

Currently, nurses are the only public health professionals providing obstetrical care in many parts of the state, Fox said.

"I'm forcing my nurses to do things we can't get the physicians to do," he said. "They're kind of left high and dry. The physicians are out there. But it's the question of money."

"One of the major contributors to infant mortality," said Barnette, "is the lack of planned deliveries. The ideal situation is to have plenty of coverage in your clinic, but to also have public nurses out there riding the circuit."

But Fox said not everything to solve the access-to-care problem requires millions of dollars.

He said two non-money moves the state could take under SOBRA would make Medicaid expansion easier.

One change would allow a pregnant woman to go into a local health department and immediately be approved for a 45-day period of eligibility as long as she applies with the Medicaid office within two weeks.

Even if she later is found ineligible, Medicaid would pay for medical expenses she incurred during that 45-day period, Fox said.

That change would make it easier to get people on Medicaid, he said.

Another possible change would eliminate the requirement for tests to see if items her family owns would disqualify a mother-to-be from Medicaid eligibility.

Horsley said those two policy changes will be made later.

Sarah Shuptrine, a human services consultant from South Carolina, said expanding Medicaid through SOBRA "is the best bet."

"Every baby should have the opportunity to be healthy," Shuptrine said. "That benefits everyone, and the less you will have to spend of taxpayers' money."

Shuptrine said reducing the infant mortality rate can be done.

In 1979 in South Carolina, where

journal photo by Mark Almond

Shuptrine speaks during infant mortality forum

she worked as former Gov. Richard Riley's special assistant for human services, infant mortality was at 17 deaths per 1,000 births.

By 1986, the rate had dropped to 13.1 per 1,000.

"Overall, 50 fewer babies died; 250 fewer were born with life-threatening conditions," Shuptrine said.

Shuptrine said expanding Medicaid coverage in Alabama to cover more mothers and children would go a long way toward eliminating barriers to prenatal care, delivery services and postnatal care.

And that availability of care would increase babies' chances to survive.

The state also must begin to implement inexpensive, innovative programs already being tested or used in other states. Grants are available for increasing prenatal care through such groups as the Southern Governors Association.

Programs such as those in Kentucky, Mississippi or South Carolina should be considered by state officials, experts said.

Rae Grad, the executive director of the National Commission to Prevent Infant Mortality, said those programs also should be geared less toward advancing technology and more toward preventive measures.

"We are improving," said Grad, "but the way we are improving is through technology, not prevention. And that's not the way it should be. The focus should be on prevention. In other words, instead of saving a low-birth-weight baby through high technology, we should concentrate on making sure that the baby is not a low-birth-weight baby to begin with."

Nurse urges teen to seek prenatal care

By Frank Bass
Journal staff writer

MARION, Miss. — Lorie Overstreet may owe her baby's life to a school nurse.

An unmarried teen-ager who got pregnant, Overstreet could have experienced a miscarriage or a stillbirth or given birth to a handicapped child.

Tragedies like that can and do happen to 17-year-old mothers. They happen when mothers don't seek proper prenatal care.

But Overstreet was lucky. Early in her pregnancy, she had the chance to talk to a school nurse.

"I guess if the nurse hadn't been there, I finally would have gone to the health department," said Overstreet, who lives with her family in a modest house at the end of a red dirt road in east Mississippi. "But it probably would have been a long time before I'd have gone there."

A student at Northeast Lauderdale High School near Meridian, Overstreet was enrolled in one of two school districts that had school nurses during the 1986-87 school year.

"Her office was like in the study hall," Overstreet remembered. "She told us if we had any problems, we were to come see her."

Early in the school year, Overstreet had problems. She discovered she was to become an unwed mother.

"I thought, it can't be true," she said. "Not me."

So she went to see Robbie McKee, a nurse assigned to the school.

"She talked to me about taking care of myself and going to the health department for early prenatal care," said Overstreet.

"I also learned about eating the right foods, that kind of thing."

As her pregnancy progressed, Overstreet found it easier to go to the health department.

She soon realized that her best chance for having a healthy baby was to continue to receive adequate prenatal care and advice from the school nurse.

"I had to keep forcing myself to go down there," she said. "It was like I already knew a lot. But she'd tell me things I didn't know."

Overstreet also enrolled in the Teen Learning Center, an academic center for pregnant teen-agers.

The center, she said, helped her to understand what it takes to have a healthy baby.

In May, her son, Lumontus, was born. Through the Teen Learning Center, Overstreet got a summer job as a clerk with the Lauderdale County Health Department. Her future looked a lot better than it had nine months earlier.

The program has been lauded for its success. Legislators voted to expand the size of the program, from the original two pilot counties to a program hiring 15 school nurses serving 16 school districts.

The state hopes to obtain more funding to hire a total of at least 26 nurses by the end of the academic year.

There's not much to having a healthy baby, said Overstreet, now a high school senior.

All it takes is adequate prenatal care and no small amount of self-esteem.

"If a girl wants a healthy baby, she should take care of herself," she said. "It's not hard. All she has to do is believe she can do it."

Journal photos by Frank Bass

Overstreet's son, Lumontus, was born in May

Mississippi no longer passes for an excuse

By Frank Bass

For years, one of the best defenses for Alabama's high infant mortality rate — and just about everything else the state had to be defensive about — has been a comparison of itself to Mississippi.

Some folks claimed Alabama's neighbor to the west was worse than Alabama in a lot of ways, including Mississippi's high infant mortality rate.

But Alabama no longer can use conditions in Mississippi to defend its own high infant mortality rate. Mississippi, so long accustomed to the bottom of all economic indicators, has decreased its infant death rate.

The National Center for Health Statistics reported the state had an infant mortality rate of 13.7 deaths per 1,000 live births in 1985 — second only to South Carolina.

The next year, the center put Mississippi's rate even lower — 11.5 — eighth worst among the states.

While Mississippi decreased its infant death rate in 1986, Alabama took over the top spot among the states. The national center reported Alabama's rate at 13.3.

Elin Holgren, director of perinatal services with the Mississippi Department of Health, said her state's decrease is attributable to several things — one being that Mississippi has "beefed up" the number and quality of services offered in county health departments.

"The causes of infant mortality are complex, and the solutions are complex," Holgren said.

She said making family planning and education available to more than 90,000 women through county health departments has helped.

She said it is through "traditional things done for high-risk people" — and poor women are high-risk — that Mississippi has decreased its infant death rate.

Mississippi's 1986 rate still was well above the 1986 national average of 10.4 deaths per 1,000 live births. However, Mississippi officials hope to continue to reduce their state's infant death rate.

"Everybody's attention is focused on the infant mortality belt," Holgren said. "So that gave us the impetus to do something."

A report released by a statewide task force in late 1985 calls for Mississippi's infant mortality rate to be no higher than nine deaths per 1,000 live births by 1990.

Most state health officials think they'll make it. They cite programs aimed at combatting teen-age pregnancy as having the potential to dramatically reduce infant mortality.

One program officials have high hopes for is the school nurse program, begun as a pilot project in two counties at the beginning of the 1986-87 school year.

"We needed some sort of initiative that would decrease adolescent pregnancy," said Carolyn Brooks, executive director of the state Commission for Children and Youth.

Brooks and health officials noted that babies born to teen-agers are more likely to suffer from low birth weight, a major factor in neonatal deaths.

"We know in Mississippi we have a problem with teen pregnancy," said Kay Bender, director of public health nursing for the Mississippi State Department of Health. "Babies born to teens tend to have more problems and die earlier. Economically, educationally, socially, they are not ready."

The school nurse program is only one of many aimed at that problem, said Bender. But after a year-long experiment in two east Mississippi counties, officials are hopeful the program is part of the solution.

"We know we can impact about 750 students per nurse," Bender said. "It costs about $21,000 per nurse. So it's not an expensive pro-

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gram by any means. That's about the cost for one baby in a neonatal intensive care unit."

After a year, state officials deemed the program a success and told the Mississippi health department to provide school nurses in counties requesting them.

But the demand, Bender said, exceeded the amount of money the department had. Funding was available for only 26 school nurses, she said.

Bender said the nurses will try to inform students of the dangers they face if they become pregnant before they're ready. The nurses, she said, concentrate more on the ramifications of an unwanted pregnancy than ways to avoid unwanted pregnancy.

"We are not about to undermine the family," she said. "The focus is to provide educational counseling and physical services. School nurses are not new by any means. It's just where they're focusing on."

Journal staff writer Emily Beasley contributed to this story.

What worked in Mississippi

- In 1985, Mississippi had an infant mortality rate of 13.7 deaths per 1,000 live births. One year later, the rate had dropped to 11.5.
- Programs that combat teen-age pregnancy dramatically reduced the infant mortality rate.
- The state's school nurse program was begun in two counties at the beginning of the 1986-87 school year. Nurses will try to educate students about the risks involved with teen-age pregnancy.

'Resource mothers' advise 1st-time teen-age moms in South Carolina

By Frank Bass
Journal staff writer

Many first-time, teen-age mothers in South Carolina, scared and concerned about the prospect of having and caring for a baby, wish they could turn to their mothers for advice.

But in many cases, that's impossible.

Their mothers abandoned them or died giving birth. And some mothers of expectant teens know little about prenatal and infant health care.

So in 1980, the state began assigning "resource mothers" to a limited number of pregnant teen-agers. The resource mothers were to help the girls obtain adequate prenatal care.

About 80 pregnant teen-agers are assigned to each resource mother. The resource mothers must visit the teens at least once a month and continue their visits through the baby's first year of life.

"The whole idea is to improve pregnancy outcome among teen-agers," said Geneva Mickens, director of the maternal health division of the South Carolina Department of Health and Environmental Control. "It did make a difference."

Mickens said in 1983 the state had an infant mortality rate of 15 deaths per 1,000 births. Babies born to teen mothers accounted for more than nearly a quarter of all infant deaths that year. The overall infant mortality rate was the highest in the nation.

But by 1986, South Carolina's infant mortality rate had dropped to 13.1, the second-highest rate in the nation. Many attribute the decrease to the resource mothers program.

"It's still high," said Madie Robinson, a social worker who began working with the resource mothers program in 1983. "But we've had a decrease since we started. The resource mothers are serving as role models for these girls. They serve as a teacher and a friend."

Marie Meglen, head of the bureau of maternal and child health care of the South Carolina Department of Health and Environmental Control, said there currently are about 20 resource mothers working in 12 of the state's 46 counties. The program is funded by a $231,000 federal grant.

"It's a big help in the areas we have it," Meglen said. "But it is limited in its focus. We are incurring long-term costs when we do not pay attention to prenatal costs."

The program is inexpensive, according to state officials. They estimate the total cost for a baby's average length of stay in a neonatal intensive care unit is $15,000.

The resource mothers, who each cost the state about $14,000 annually, are believed to prevent at least two low-birth-weight incidents and other problems in a year.

At least one Alabama health care expert who visited South Carolina said she was impressed by the resource mothers program. Rebecca Work, an assistant professor at the School of Public Health at the University of Alabama at Birmingham, said the program encourages teen-agers to get needed prenatal care.

"There's a lot of commitment there," said Work. "It's an excellent program. The more knowledge they have, the sooner they're likely to get help."

Agreed Alvonia Brown, a resource mothers supervisor: "We encourage them to think of the future. I feel strongly, however, that these girls have got to want this for themselves. Often, it's not that they don't want to come to get prenatal care. They just don't know how to get to prenatal care."

Mickens said the program will have to be funded entirely by the state after 1988. Although she said the resource mothers program should sell itself, Mickens said obtaining funding for infant mortality programs is not always easy.

"This program is not being viewed as a priority," Mickens said. "Unfortunately, sometimes it takes an individual crisis, although I hope that doesn't happen to anybody."

What worked in South Carolina

- In 1983, the state had an infant mortality rate of 15 deaths per 1,000 births, the nation's highest. By 1986, the rate was 13.1.
- In 1980, the state began assigning resource mothers to pregnant teen-agers to help the girls obtain adequate prenatal care.
- The resource mothers must visit the teens at least once a month and continue their visits through the baby's first year of life.

Time, effort help turn Kentucky crisis around

By Frank Bass

Dr. Robert Bednar remembers the time and effort needed to turn Kentucky's infant mortality crisis around.

For two years, he joined civil leaguers, mothers and concerned citizens in waging an often lonely and seemingly endless battle against the state's high infant death rate.

"Things were quite severe," said Bednar, a Montgomery pediatrician who practiced in Lexington, Ky., during the late 1970s.

"There were many babies being born in rural areas who could not be admitted to high-risk medical care centers," he said.

Instead of being able to send infants born under his care to centers in Lexington or Louisville, he was sending babies with problems to Cincinnati or Nashville, Tenn., he said.

The children were sent away from their homes because there were not enough neonatal intensive care unit beds in the state — meaning there was not enough space in hospitals for newborns with serious health problems.

"We enlisted all types of organizations" to make the public aware of the problem, Bednar said. Two years after a massive awareness program began, Kentucky's legislature had expanded neo-natal intensive care units and had provided extra funding to combat infant mortality.

In 1980, the problem reached critical proportions. But by 1986, Kentucky recorded an infant death rate of 9.2 per 1,000 live births — a nearly 30 percent drop from the rate of 12.9 in 1985. These figures were reported by the National Center for Health Statistics.

Even so, work on the problem continues in Kentucky, with programs such as one designed to educate public health nurses about how best to teach high-risk mothers about their bodies.

The Kentucky program began early this year. Both the private and public sectors are participating. The state provides the training and the people to be trained, and the March of Dimes provides the training materials.

"We looked at the major cause of infant mortality," said Shana Funk, a March of Dimes regional program director in Louisville.

"You can control the weight of babies by the health of the mothers. So the March of Dimes decided to attack low birth weight."

Attacking low birth weight, explained Kentucky Health Commissioner Carlos Hernandez, entails curbing the number of premature deliveries. Those premature deliveries, he said, are the leading cause of infant mortality.

"Low birth weight is the leading cause of infant deaths," he said. "If we can do something about premature deliveries, we can lower Kentucky's infant mortality rate."

The idea is simple and inexpensive. Mothers involved in the program attend weekly prenatal clinics instead of the monthly clinics normally offered to expectant mothers.

The mothers also are taught signs of premature labor and meet regularly with nutritionists.

The program is relatively new. Yet many in the health department are lauding the identification program as something that will further cut infant death rates.

In the six months since the program began, seven sites serving 18 counties and 143 patients have been established. The program, said Ted Hanekamp of the Kentucky Department for Health Services, has an annual budget of $1 million.

"It's too soon to tell yet whether we're going to have a positive impact on infant mortality," he said. "But we can quote study after study that says there's no doubt prenatal care can and does have a positive impact."

Bednar said Kentucky's experience shouldn't be seen as unique.

"There was a need, it was recognized, and something was done about it," he said. "It was an example where government acted."

Journal staff writer Emily Benites contributed to this story.

What worked in Kentucky

- The 1980 infant mortality rate was 12.9 deaths per 1,000 live births. In 1986, the rate had dropped to 9.2.
- Public and private sectors are part of program to reduce infant mortality rates.
- Mothers in the program attend weekly clinics where they are taught signs of premature labor and meet regularly with nutritionists.

Neighboring states map strategies, combat problem

By Frank Bass
Journal staff writer

Alabama is not the last place in the country where the problem of infant mortality has become a subject for concern.

But it's close.

In the "infant mortality belt" of the Southeast, states with traditionally higher infant death rates than Alabama's are beginning to launch a series of innovative programs.

In 1984, the Southern Governors Association declared war on high infant mortality rates. It was a war Alabama declined to wage.

Instead, the state remained complacent because it had an infant death rate that approached — but did not quite equal — the worst in the country.

The results of complacency were made clear on April 15. State Health Officer Earl Fox announced Alabama had the highest infant mortality rate of any state in the country for 1986.

While state officials and politicians scrambled to find ways of reducing the state's infant death rate, people in three other Southeastern states already had been at work on the problem.

The programs in South Carolina, Kentucky and Mississippi were not original. And they weren't costly. But they have reduced infant death rates.

What made these states different? Why did they care?

"I think there has been a real resurgence of interest here in people," former South Carolina Gov. Richard Riley said. "We had struggled for equity in education for years. We were seeing our people not getting the kind of quality start in life they should be getting, and that folded over into health.

"But it's not just a leadership issue," he continued. "It goes a lot deeper than meetings and seminars and task force reports. When we talk about one child dying, we're also talking about thousands of young Southern children, black and white, going into an exciting, competitive world with disabilities."

The three states used a number of approaches to reduce their soaring infant death rates. But three programs stand out.

- In South Carolina, about a dozen women have been hired to serve as "resource mothers." They work with young women who are pregnant for the first time.

The mothers ensure that the young women receive adequate prenatal care and teach them how to care for their babies. Resource mothers continue to help the new mothers for a year after their deliveries. The program has a $231,000 federally funded budget.

- In Kentucky, the March of Dimes Ohio Valley Region has begun providing instructional materials for public health nurses. The materials help the nurses instruct high-risk mothers in proper prenatal care.

The high-risk mothers attend clinics, and public health nurses teach them how to care for themselves and their babies. The annual budget for the program is about $1 million.

- In Mississippi, a school nurse program was begun in the fall of 1986. Started as a pilot project in two eastern Mississippi counties, the program is being expanded this year to cover 22 counties.

The program, which costs about $550,000, is geared toward helping adolescents understand the risks of teen-age pregnancy. A high incidence of teen pregnancy is thought to be a major contributor to a high infant death rate.

States like Mississippi have recognized what will happen if they don't attack the infant mortality problem.

In 1985, a task force looking at infant deaths in Mississippi called the state's infant mortality rate "devastating to Mississippi's health and economic status."

That was hard, plain talk about a complex problem.

Officials in other states said that's a necessary first step on the road to solving the infant death problem.

Governor: We don't intend to ignore the problem

By Emily Bentley
Journal staff writer

Gov. Guy Hunt says he's "willing to do anything" to fight Alabama's high infant mortality rate, but some say his wait-and-see approach means more babies will die needlessly.

With an infant death rate of 13.3 deaths per 1,000 births last year, Alabama's infant mortality rate is worse than any other state in the nation.

"Maybe it's been ignored a long time, but we don't intend to ignore it," Hunt said in a recent interview with The Alabama Journal.

In July, Hunt appointed a task force to study why so many babies die before their first birthday and how to reduce those statistics.

Hunt said the task force will have a conference in January to get business people involved in the solution.

"It is a real problem, and we're serious about it," Hunt said.

Sen. Mac Parsons, D-Hueytown, said Alabama's infant mortality ranking shows that the state's priorities are "out of kilter."

"He should have done more than refer it to a committee," Parsons said of Hunt.

"That means 600 more babies are going to die in the next year without the attention they deserve," Parsons said. "The problem has been studied long enough."

But Hunt said he does not agree with the approach that all that is needed is more money.

"I don't believe that," Hunt said.

Hunt said he views Alabama's infant mortality rate as a problem of education rather than one of poverty.

"I think it's a crisis from the standpoint that we have some programs — that we feel like if some of the mothers would take advantage of them in the first year, that we could save some of these babies," Hunt said.

Hunt said only 16 percent of the people eligible for such programs are taking advantage of them.

What he was referring to, however, is that only people with income below 16 percent of the federal poverty level — meaning earning up to $1,416 per year for a three-member household — are eligible for Medicaid in Alabama.

Hunt said Medicaid and Human Resources staff members are working on getting federal matching money to pay for more deliveries.

But during the last legislative session, Hunt's appointed Medicaid Commissioner, Mike Horsley, turned down an opportunity to extend Medicaid coverage to more mothers and infants, effectively delaying such a move until 1988.

Horsley told legislators he could not use $5 million they offered his department for Medicaid expansion. Through the federal Sixth Omnibus Budget Reconciliation Act (SOBRA), the state could get $3 in federal funds for every state dollar so that more mothers-to-be would be covered by Medicaid.

Horsley said the $5 million — $7 million to $8 million is needed for the state's share of the program — would not have been enough money to fund it for a year. Horsley has a plan to draw the state money from local governments and private donations, through a Mothers and Babies Indigent Care Trust Fund.

Sen. Jim Bennett, D-Birmingham, said $1 million the Legislature appropriated for the expansion was done without assistance from the governor's office. "Hunt just sort of jumped on the bandwagon," Bennett said.

Bennett said Hunt's pocket veto of a legislative resolution calling for expansion of Medicaid coverage beginning in January showed the administration's attitude about the problem.

"I don't remember pocket-vetoing anything that dealt with it," Hunt said.

In the interview, after being told about the resolution, Hunt said: "It didn't have the force of law." Such resolutions express legislative intent.

Hunt said he probably vetoed the resolution because it recommended that the

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Journal photos by Jay Sellers

'It (infant mortality) is a real problem, and we're serious about it,' Hunt says

amount obstetricians are paid for a Medicaid delivery be increased from $450 to $750, which would be as high as any state in the country.

But Bennett said when you're the worst in the country, "it requires drastic action."

Bennett added, "It shows a gross misunderstanding of the lack of prenatal care."

Hunt said he thinks "we're giving them what funds they'll be able to use. I don't see it as they need any more funds. If they do, we'll go back to the Legislature when they come into session."

"If you were to give them $50 million, they might not be able to reduce it more than 1 (death) per 1,000 unless we attack the other areas," Hunt said.

He said infant mortality had not been addressed before because most people were unaware of the problem. Alabama's infant death rate is not "that much higher" — just a point or two — above the other states, Hunt said.

But he admitted it is a problem.

"I think it's a combination of several things," Hunt said.

Hunt said the legal liability associated with delivering babies has driven doctors and hospitals out of the baby business.

Hunt said mothers often have to travel 50 to 60 miles to deliver or see a doctor.

"We may have to start looking at ... providing scholarships for people who are going into the rural areas to practice among the people who really need them," Hunt said.

"I think it should be pointed out that the quality of care that we're receiving at a lot of our institutions in our state is the highest of anywhere in the world," Hunt said.

But experts say the poor are not getting that care, and that, for the state, prevention of problems would be less costly than the miracle of modern medicine.

Ted Williams, chairman of the state chapter of the American Academy of Pediatrics, said the Medicaid Agency should expand eligibility to 100 percent of the poverty level so that more women will have access to care.

"It may not be just a money problem if we didn't have the capability of getting the program going," Williams said, referring to Medicaid expansion.

"Somebody's got to light a fire under the governor's office and the Medicaid Agency," Williams said.

Although government and business leaders say the infant mortality rate discourages companies from locating or expanding here because it indicates a poor quality of life, Hunt disagrees.

"We have not found this to be hindering our industrial development at the present time," Hunt said.

"They (businesses) know that this is something you don't accomplish overnight. And they see us as taking positive steps to deal with it," he said.

Hunt said other states' success — South Carolina's, for example — in fighting infant mortality is the result of programs that have been in effect several years.

"If you got some good positive programs dealing with it and you drop it four or five (deaths) per thousand (births), you've put your state in a much better place," Hunt said.

Parsons said Hunt should be concerned enough about Alabama's infant mortality rate, which is worse than that of Costa Rica, to take immediate action.

"It's a matter of priorities. His (Hunt's) priorities say that creating a good business and corporate climate is more important than creating a good people climate," Parsons said.

"We should be funding a plan that takes care of our working poor," he said. "Healthy babies should come before corporate dividends."

To such criticism, Hunt replies he wants to examine the issue thoroughly before committing funds.

"That's not putting off until next year. We don't think you can throw money at any problem," Hunt said.

He said he is doing enough for the present.

"We need time to study. ... We need to decide what to do to educate people," Hunt said.

But Sarah Shuptrine, a human services program consultant from South Carolina who talked with Hunt about the problem this summer, said Alabama should implement Medicaid expansion through SOBRA as quickly as possible.

"We know about the problem. It shouldn't take long to study," Shuptrine said. "You don't have to reinvent the wheel."

Infant mortality price tag exceeds prevention costs

By Frank Bass and Emily Bentley
Journal staff writers

The death of a baby in Alabama is not without a price.

In terms of emotional suffering, the death is likely to be the most expensive loss of the parents' lives.

But there are real financial costs of the tragedy as well. And these costs greatly exceed the cost of preventing the tragedy.

The financial costs can be measured in dollars. Alabama spends $62 million per year on health care for low-birth-weight babies, said Dr. Earl Fox, state health officer. Inadequate prenatal care and teen-age pregnancies often result in low birth-weight babies.

Care for disabled children, often born to women who receive inadequate medical care before birth, is even more costly.

Hospitals and doctors bear some of the costs when patients cannot pay. Most of the costs eventually are shifted to paying patients through higher fees.

But the financial toll of infant deaths can be illustrated in ways more difficult to quantify. It is the cost of lost productivity, the loss of badly needed jobs when business and industry see Alabama's high infant death rate as a sign of a continued lack of progress.

Last year, 788 babies died before their first birthday, giving Alabama the highest infant mortality rate of any state in the nation.

For every baby who dies, statistics show eight to 10 babies are born with complications or disabilities that require additional care. And more care means more cost.

"We are an instant gratification society," Fox said. "We want to see our results now. The infant death rate is only the tip of the iceberg. I think people tend to forget that."

Fox said having an underweight baby kept alive for weeks in a hospital neonatal unit — with high-tech equipment and highly trained nurses and doctors — is more exciting, more glamorous than providing prenatal care in every county.

But it is more expensive, he said.

Fox and other experts suggest a solid investment in prenatal care, which could dramatically reduce infant deaths.

For now, the brunt of the state's burden of providing health care for expectant mothers falls on the Alabama Medicaid Agency and the Alabama Department of Public Health.

Most taxpayers and politicians tend to view appropriations to these agencies as a necessary evil. Funding for the agencies is often given grudgingly.

Yet for every $1 spent on prenatal care, $3.38 is saved in the treatment of a low birth weight infant, according to the Institute of Medicine, a Washington-based health care research group.

For every $1 spent on prenatal care, $10 is saved on the long term costs for the treatment of a mentally disabled person.

The costs of infant mortality, then, are high — but how high?

Former Alabama Medicaid Commissioner Faye Baggiano estimates close to $20 million annually is spent on prenatal and delivery services for Medicaid mothers in this state. That figure, she said, does not include the average of between $5,200 and $13,000 charged for a neonatal intensive care unit for a low-birth-weight baby.

Nor, she said, does that figure include the $42 per day charged for placing an extremely disabled baby into a nursing home for life. However, most extremely disabled children don't live to adulthood.

For children who spend weeks in a neonatal care unit, costs can run from $14,000 to $150,000, said Sarah Shuptrine, a human services consultant from South Carolina.

A healthy birth costs about $2,000.

"We're paying for our neglect in a big way," Shuptrine said.

Rae Grad, executive director of the National Commission to Prevent Infant Mortality, said the cost of placing five children in a neonatal intensive care unit is equal to providing 150 women with prenatal care.

"When you look at those kinds of comparisons, how can it be we're not putting our emphasis on prevention?" she asked.

Costs are not limited to the state, however. Hospitals incur huge losses from providing obstetric care to expectant mothers.

Tommy McDougal, executive director of the Alabama Hospital Association, estimates somewhere between 20 percent and 40 percent of all hospital bad debts are related to obstetrics. He said the debt could be reduced by expanded Medicaid coverage.

"In Alabama, that's a total of about $250 million," McDougal said.

Expanding the Medicaid program, agreed Baggiano, would cost money. But she said the cost would be minimal.

A recent study by Baggiano shows the 1985 infant mortality rate among Medicaid mothers in Alabama was only 10 deaths per 1,000 live births. The figure was a substantial decrease from the figure of 13.3 for all mothers.

"We know the infant mortality rate for Medicaid mothers is not as high as the rate for the general population," agreed Medicaid Commissioner Mike Horsley. "That appears to be the answer."

Medicaid mothers have a lower infant death rate than the rest of the population, experts say, because Medicaid enables women without private insurance to get prenatal care. He said once a woman is brought into the health care system, she is educated about prenatal care, parenting and birth control.

But the Medicaid agency must discover a constant revenue source to raise money for a 3-to-1 ratio of federal matching funds, said Horsley.

Once the state commits to raise money for the matching funds, it must continue to use that amount of money or a greater amount to continue receiving matching funds.

Medicaid is not the only state agency with a tight budget.

Like his colleagues, Fox must fight for every dollar he gets in the state budget. But Fox also realizes that the cost of ignoring infant mortality exceeds the cost of curbing it.

"I think the prenatal system is shaky enough without having to go six or 12 months with no dollars," Fox said. "And we don't need to rob Peter to pay Paul. What we need is to maximize Medicaid and have some money available for non-Medicaid eligibles."

State agencies, hospitals and parents can give estimates on how much inadequate prenatal care costs them. But there are costs to the state and its people that are not as evident as a hospital bill.

The administration of Gov. Guy Hunt has announced its intentions to boost the state's business climate. Yet for every child who dies for a lack of adequate prenatal care, the business community suffers.

And in an era of competitive infighting among states for new industry, that's bad news for Alabama. Potential new businesses, using infant mortality as an indicator of the quality of life, are less likely to locate in the state.

"Industry knows. Infant mortality is a surrogate variable; it captures the quality of life," said Christiane Hale, director of the maternal child health program at the University of Alabama at Birmingham.

Hale equated the state's infant mortality rate with a "canary in a coal mine." Miners used to take the small birds with them to make sure there was enough air and no noxious gases escaping. They would watch the canaries. If the birds acted strangely or became ill, the miners retreated from the shaft.

"When the canaries died, the miners got out. When babies die, that's an indication something is wrong," she said.

She said that unless Alabama lowers its infant mortality rate, people will continue to perceive the state as being backward. Industry, she said, will continue passing Alabama by for other, more progressive states.

"I don't know how to put a cost in dollars of infant mortality to society," said McDougal. "There's just no way to get a handle on that. But we're smart enough to know that reducing infant mortality has a ripple effect."

Pay now or pay later

Health experts say that while technological breakthroughs that save babies' lives are good, common sense prevention approaches are being ignored. The costs of waiting until after birth to provide health care are detailed below.

- Number of women who could receive prenatal care for the average cost of one baby's stay in a neonatal care unit: **30**
- Cost of a normal delivery: **$2,000**
- Cost of a delivery of a low-birth-weight baby with neonatal care: **$8,200 - $13,000**
- Cost of an extended stay in a neonatal unit: **$14,000 - $150,000**
- Yearly cost of residential care for a retarded or handicapped child: **$37,500**
- Yearly cost for a regular classroom education for one child: **$2,016**
- Yearly cost for a classroom education for a child with a hearing or speech impairment: **$4,200**
- Amount saved for every dollar spent on prenatal care: **$3.38**

Sources: Alabama Department of Public Health, Sarah Shuptrine & Associates

Journal graphic by Phyllis Perry

Legislation on infant mortality has been long time coming, some feel

By Emily Bentley
Journal staff writer

Although Alabama legislators made a last-ditch attempt in the 1987 session to provide money for more prenatal care for the state's mothers-to-be, many say lawmakers could have — and should have — done more. Sooner.

The little money that was appropriated to fight Alabama's worst-state-in-the-nation infant mortality problem was given primarily because of the efforts of a few senators and prenatal care advocates.

Sen. Jim Bennett, D-Birmingham, said the $1 million appropriated for more Medicaid coverage for mothers and babies was approved without any help from the governor's office.

Another effort — a joint resolution sponsored by Bennett, along with Sens. Hank Sanders, D-Selma, and Michael Figures, D-Mobile — called for the implementation of Medicaid expansion and an increase in how much doctors are paid to deliver Medicaid babies.

Gov. Guy Hunt pocket-vetoed it.

Sanders said legislation addressing infant mortality has been a long time in coming because his colleagues were more concerned with helping the rich avoid lawsuits than helping the poor keep their children alive.

Sanders said legislators failed to see the importance of infant mortality sooner because they were focusing their energies on tort reform, a set of laws changing the way civil lawsuits are handled in the state.

The Legislature passed tort reform as its first priority in 1987, portraying the law changes as the way to bring down insurance rates for everyone, including doctors. By decreasing malpractice insurance rates, tort reform also would increase the availability of health care, proponents said.

"I don't think the tort reform issue was about providing more services to the poor; it was about providing more money to the rich," Sanders said.

And because issues are made by lobbyists, Sanders said, funding to combat the state's high infant mortality rate got bumped aside.

"This concerns, essentially, poor people. And there's no lobby for poor people," Sanders said.

Lt. Gov. Jim Folsom Jr. named some of the issues before the Legislature during this past session, including tort reform, parental consent for minors' abortions and the budgets. Amid all of the issues, infant mortality "did not emerge as a premier issue," he said.

A lack of awareness among lawmakers that there was an infant mortality problem also kept the issue in the background, Folsom said.

A week before the Legislature's regular session began, State Health Officer Earl Fox announced that Alabama had moved into the number one spot among states in infant deaths.

"Before Dr. Fox came along, nobody had all the information and compiled it the way he had and distributed it," Sanders said.

Now that legislators have been informed, "it should have the highest possible priority in the next Alabama Legislature," Sanders said.

Folsom said only recently has enough attention been focused on the problem to get the Legislature to look at ways to combat infant mortality.

The small group of senators initiated an additional $1 million appropriation for the Alabama Medicaid Agency to begin to expand Medicaid coverage, or government-subsidized health insurance, to more pregnant women.

The program would allow pregnant women who earn more than the $1,416 annual income limit allowed under the current Alabama Medicaid system to get medical benefits during their pregnancies and for the first year of the baby's life.

The senators began their effort after a Democratic Issues Forum brought the issue to the forefront — only six working days before the legislative session was to end.

They attempted to give the Medicaid agency $5.2 million, but that was reduced to $1 million when Medicaid Commissioner Mike Horsley said he could not use all the money in the first year of such a program.

Full implementation of the expansion would cost between $7 million and $8 million in state funds, and draw three times that amount in federal dollars, according to Horsley.

But reorganizing eligibility procedures and paperwork would take awhile, Horsley said.

He said Medicaid expansion under SOBRA, the federal Sixth Omnibus Budget Reconciliation

(Please see TIME Page 18)

Action in the State House

In the 1987 regular session, the Legislature:

- included an extra $1 million in the General Fund budget appropriation to the state Medicaid Agency to expand Medicaid coverage to more women and children. The Legislature did not include the full amount needed to fund the program — $8 million for 1987-88.
- funded the state Department of Public Health's perinatal education programs at $2 million.
- passed a Mothers and Babies Indigent Care Trust Fund bill to collect money from cities, counties and private sources to draw federal matching dollars for Medicaid coverage.
- did not consider a cigarette tax increase to help fund prenatal care and education.
- passed a resolution calling for Medicaid coverage up to 100 percent of the federal poverty level. Gov. Guy Hunt pocket vetoed the resolution.

Journal graphic by Phyllis Perry

Time

Act, would need a continuous funding source, and he does not think enough would be available in the 1988 General Fund budget.

But Sen. Mac Parsons, D-Hueytown, said Horsley "sandbagged" the Legislature on what the options were for fighting infant mortality.

Parsons

Although Horsley said his agency would need time to set up the expanded Medicaid program, Parsons said, "I found out later it's a program you either put into effect or you don't.

"It's like being pregnant. You're not a little bit pregnant," he said.

Folsom said he worked with Horsley on how to fund and how much to fund the Medicaid expansion program.

While the Medicaid expansion program was not fully funded, the Department of Public Health was able to keep $2 million for its perinatal education programs throughout the state despite money juggling that threatened the appropriation more than once.

The programs are important in teaching local nurses how to handle problem deliveries and in educating women in how to avoid problems, Fox said.

Fox said legislators weren't willing to step out on a limb and support a 5½-cent cigarette tax increase to save the babies of Alabama.

Fox said his proposal to increase cigarette taxes never got off the ground because of a general anti-tax attitude in the Legislature and Hunt's administration.

Fox worried whether tobacco lobbyists would be too persuasive to let such a measure pass, and, in fact, he never was able to get a sponsor for the bill.

Fox said the increase would have raised $23 million annually for the Medicaid expansion and for cancer prevention efforts.

"We may bring it back again next year," Fox said.

Fox said when it costs $1.25 for a pack of cigarettes, he does not think an extra 5½ cents would hurt smokers.

Fox said the money situation can be traced at least partially to the lack of a state trust fund for health.

"The Health Department and Medicaid have to depend on the General Fund, probably the most strapped of the state government," Fox said.

Fox said state government is much like the members of a poor family who can only see themselves through one day at a time. There is little planning for the future.

He said the cigarette tax would have helped alleviate that problem.

Fox said whether it is new money raised through certain tax measures or redirected funds the state already collects, money spent for prevention of problems — through accessible prenatal care — would be a wise investment.

But Sanders said it was "extraordinary that we were able to do what we did. I think we made a major contribution in what was done."

Folsom said legislators addressed it as well as possible this year.

"We'll come back next year, and the problem is still going to be there. My guess is that it will require more money," Folsom said. "We're going to have to come up with the bucks."

Fox said legislators are just realizing the implications of infant mortality.

"In a state like Alabama, you're talking about where are you going to get the money — we're talking about somewhere between $5 million and $7 million dollars to implement that program (SOBRA). I guess I'm a little prejudiced, but I feel if it's a priority, funding could be found."

Greene program reduces infant deaths

By Susan Eggering
Journal staff writer

EUTAW — Much can be done to combat infant mortality with a relatively small bankroll.

Greene County is a prime example. Although in 1984 it was one of the nation's 10 poorest counties, it has managed — with some philanthropic help — to implement a program aimed at lowering its infant mortality rate.

The program provides medical care to women during pregnancy and following childbirth, as well as educates them and gives them emotional support. A total of 165 women have been involved in the program since it began about three years ago.

Already the results are visible.

Of the 181 babies born in Greene County in 1986, only one died, according to statistics from the Alabama Bureau of Vital Statistics. That translates to a rate of 5.5 deaths for every 1,000 live births.

That's a vast improvement from a rate of 54.9 for 1947-51, 42.6 for 1962-66 and 18.7 for 1977-81.

Even as late as 1985, seven babies in the county died, giving the county an extraordinarily high infant death rate — 39.8.

But even though only one baby died in 1986, a doctor in the county says the program is as badly needed as ever before.

"We are now seeing more women who are showing up to deliver who had no prenatal care," said Dr. Sandral Hullett, health services director at West Alabama Health Services in Eutaw. "It's almost like it was when I started working here nine years ago."

But more than good prenatal care is necessary to lower infant mortality rates. Just as crucial is a system of postpartum follow-up, she said.

An encounter with the mother of a newborn several years back drove home that very idea.

Wanda Newell
— Puts emphasis on preventive health care

"She brought the baby back for a two-week checkup, and I was appalled," Hullett said. "The baby was skinny. We weighed it. It was 3 pounds. She said she couldn't wake him up to feed him."

Hers was not an isolated incident.

"The problem was seeing a lot of cases like that," Hullett continued. "I thought there must be some way we can work to educate our women, and there must be some way we can keep up with them when they go home."

The Rural Alabama Pregnancy and Infancy Health (RAPIH) Program is aiming to do just that. A joint, three-year project of the Eutaw clinic and the University of Alabama's College of Community Health Sciences, the program was implemented in late April 1984, underwritten by a $300,000 grant from the Ford Foundation.

Ford recently granted a two-year extension of its funding, after which the federally funded clinic plans to continue the program itself.

The RAPIH program, similar to one that's been successful in South Carolina, takes a holistic approach to the prevention of infant mortality, providing complete health care to eligible pregnant women at no charge, as well as assisting first-time mothers in developing parenting and child development skills.

"We're looking at more than just the medical aspect," Hullett said. "There are social support systems they need. It's not all just coming to the doctor and taking a pill. There's a mental, a psychological and a physiological aspect, and we're trying to pull them all together. It's idealistic, but that's what it is. It's getting people to understand that they have a role in their health care and that health services have a role, and by working together, we should get a real good result."

The program serves women in Greene, Hale and Sumter counties who are the patients of physicians at the Eutaw clinic, utilizing the expertise of the medical staff, as well as that of workers from other agencies and nine home visitors. The mothers are recruited by the RAPIH program supervisor, home visitors and other mothers participating in the program. Local health care providers and area community social service agencies also refer women.

"In the program, we work with high-risk women and follow them intensively," Hullett said.

On average, these women are single, high-school graduates who are about age 19. All but one of those participating in the program are black. The young women tend to live either at home with their mothers or in substandard housing which often lacks a bathroom and running water.

Others dwell in government-subsidized housing with six to eight family members and often have no phone or car. The young mothers often receive no support from the fathers of their babies, making food stamps and Aid to Dependent Children (welfare money available to single mothers and their children) their sole means of support.

"We've found that in this group of women we have had a very good outcome," Hullett said. "We have had no mortalities in this group, and we've had just a very small amount of low birth weights."

Those babies who were low-birth-weight had mothers who did not seek prenatal care until very late in their pregnancies. Though the majority of women participating in the program do not come for medical care until their second trimester, none of the babies born to mothers in the program were under 3½ pounds.

The keystone of the program is the home visitor assigned to each client. She is a community woman, trained in the latest health techniques for mothers and infants, who acts as a "big sister" to the participant throughout her pregnancy, delivery and for the first two years of her child's life.

"Our home visitors are women in the community who are well respected and who have been mothers themselves," said Wanda Newell, formerly the field supervisor for the project. "I think the advantage of using someone in the community is that she's in tap with the cultural norm."

The one full-time, eight part-time home visitors average about 12 to 15 cases each. They receive continuing education on a weekly basis and discuss with the field supervisor any problems they've encountered.

The home visitor offers informational and emotional support, assists in problem solving and helps mothers locate the resources they need. She discusses with her clients the different stages of pregnancy and child development.

Home visits, which run from 40 minutes to one hour, are made once every two weeks during pregnancy, once after delivery in the hospital, three days after discharge from the hospital and once every two weeks for the first six months of a baby's life. After that, visits are decreased to once every four weeks for the next six months, and once every six weeks during the baby's second year of life.

"During the prenatal (period), they act as an emotional support, they encourage keeping appointments, (help in) preparing for when the baby comes home from the hospital and supplement what they learn in the prenatal classes in the center," Hullett said.

"For the postpartum (period), they follow mother and baby, helping mothers understand the normal course of growth and development and helping them with what they have to deal with emotionally and with some sort of family planning if they're interested," she said.

"I think that the challenge is to convince the mother to seek care early and use the system for preventative health care," Newell said.

Depending on the baby's age and the mother's questions, the home visitor may conduct a lesson on the proper way to fit and buy baby shoes, or how to child-proof a house, she said.

This may seem simplistic, but such basics are given little thought when a mother is concerned about putting food on the table and keeping a roof over her head.

"They are concerned with shelter, feeding and keeping that baby dry, and, if they do that, they think he will grow up fine," Newell said.

"What we're trying to do is introduce (things) that are different from their lifestyle. It's not ignorance. It's just that usually low-income people think day-to-day. And we're trying to get them to think what that baby in their arms will be in 20 years and how they can better equip that baby to get there," she added.

"We persuade the mothers that they have control over their lives and their babies' lives," she said.

The challenge seems to be working.

"Some of our mothers have begun to assess their lives and get jobs," Newell said.

Several have gone back to school, some have received their Graduate-Equivalency-Degree diplomas, and others have learned such basic life survival and job skills as driving, typing and how to make their government aid last the entire month.

The first home visitors donated their time, but it quickly became evident that they were having to dip into their own pocketbooks to finance their volunteer effort. Now they are paid minimum wage. While this has made no difference in the quality of their work, it has affected the way in which they are perceived by the mothers they serve.

"It wasn't that they did better work on their part, but they were looked at differently in the community," Newell said.

All in all, those associated with Greene County's program are pleased with its success and believe it could serve as a prototype for other Alabama counties.

"I think the cost effectiveness of the program makes it feasible when we look (at the costs) of (keeping) a newborn in a neonatal nursery, or carrying over children with handicaps," Newell said.

"If you can prevent one $20,000 baby from being in the nursery, it's an effective program," Hullett said. "We're helping not only to keep that baby out of the nursery, but (helping) that mother to have a positive attitude. We're looking at the long range. This child will probably stay in school and become an effective citizen. We think it's a small investment to make for the long run."

Money for life

Money is always a problem in Alabama government, but that does not excuse the state's failure to properly address a serious, life-and-death problem like infant mortality. Significant federal assistance is available if the state will come up with some funds to increase Medicaid coverage for mothers and children.

Alabama's infant mortality rate is the nation's highest — 13.3 deaths per 1,000 live births in 1986. In some counties, the rate is as high as in many Third World nations. That's more than an embarrassment; it's a tragedy.

There are many reasons for it: poverty, ignorance, lack of transportation. There is also one universally recognized way to combat the problem — better, more widely available prenatal care.

Too many Alabama mothers get inadequate prenatal care. Some get none at all, seeing a physician for the the first time only shortly before delivery. There are many reasons for this as well, but the primary one is money.

For poor women without private or government insurance coverage, the cost of prenatal care can be prohibitive. Medicaid coverage would provide that care, but there is a cruel catch to that in Alabama.

The state's Medicaid eligibility limit is 16 percent of the federal poverty level. That means that those eligible are those earning less than $1,416 per year.

Obviously, one could earn substantially more than that and still be in very difficult circumstances. At issue are not just indigent Alabamians, but in many cases the working poor, the underemployed, people trying to earn a living.

If the eligibility limit for Medicaid were increased, many more mothers could be brought into the program and receive the prenatal care essential to the health of their children. There is a way to do it, with help from federal funds.

To get this help, the state must act under SOBRA, the federal Sixth Omnibus Budget Reconciliation Act. For every dollar Alabama puts into SOBRA, the federal government kicks in almost three.

One needn't be a financial genius to see that state money put into SOBRA is a superb investment. Nor is fiscal wizardry required to see that prenatal care — in purely monetary terms, the human element aside — pays off exceedingly well.

In the long run, it is far less expensive to provide adequate prenatal care, with the resulting healthier babies, than to pay the often astronomical medical bills incurred by low-birth-weight babies. The benefits in human terms are incalculable.

That is why SOBRA makes so much sense for Alabama. There are plenty of other things that need more money in this state — schools, roads and the like — but the plain truth is that Alabamians are not dying of potholes or crowded classrooms, serious as those concerns may be. They *are* dying, at awful rates, as a result of inadequate prenatal care and a system that, if unchanged, will only perpetuate the problem. — **The Alabama Journal, October 4, 1987.**

Alabama tragedy

In some parts of Alabama, babies die at rates as bad or worse as those of Third World countries. Our infant mortality rate is the highest in the nation.

This tragedy — and it is precisely that — arises from poverty, ignorance, apathy and misplaced priorities, as The Journal reported in a five-day series of articles last week. Many of these deaths could be prevented.

The single most important factor in the high infant mortality rate is deficiency in prenatal care. For a variety of reasons — lack of money, lack of transportation, lack of knowledge — thousands of Alabama women get inadequate prenatal care. Some get none at all, seeing a physician only shortly before delivery.

A terrible price is paid for this, in both human and fiscal terms. Low birth weights are common and these infants have more medical problems — and higher medical expenses, often borne by the taxpayers. Proper prenatal care could prevent much of this expense and many of the deaths.

The human cost is immeasureable, of course, but there are some dollar figures that reveal the folly of failing to invest in prenatal care. For every dollar spent on prenatal care, $3.38 is saved in treatment of low-birth-weight babies. Every dollar spent on prenatal care saves $10 in long-term costs for treating a mentally disabled person.

The charge for a neonatal intensive care unit for a low-birth-weight baby may run $13,000. If a baby must spend weeks in a neonatal unit, the cost may be $150,000. A normal delivery averages about $2,000.

Thirty women could receive prenatal care for the average cost of one baby's time in a neonatal care unit.

Expansion of the Medicaid program would go a long way toward solving the problem. The program allows women without private health insurance easier access to prenatal care. A survey has found that Medicaid mothers have a significantly lower infant death rate.

This, naturally, would carry a cost, but nothing like the expense of caring for low-birth-weight babies. Economically, it simply makes sense. In human terms, it is unquestionably the right thing to do. — **The Alabama Journal, September 23, 1987.**

Out Of The Way

With more than 13 out of every 1,000 babies born in Alabama dying before their first birthday, this state leads the nation in infant mortality. But it doesn't have to be that way.

Other states have found ways to reduce their infant death rates. In 1984, the Southern Governors' Association made reducing infant mortality its highest priority, producing a spate of initiatives to reduce the rate of infant deaths in their states.

Alabama politicians sat on their hands. There was no concerted effort to fight infant mortality; there was no indication that Alabama leaders thought it deserved a high priority. The result: Alabama now leads the nation in infant deaths.

This state is accustomed to being at the bottom in measures of economic status and education, but the infant death statistics are more shameful than all the other rankings combined.

As a week-long series in The Alabama Journal has made clear, there are many causes for high infant death rates. No one program is going to solve the entire problem, but there are things that work.

For instance, Mississippi started a program to combat teen-age pregnancy. Kentucky enlisted private businesses in massive public education program. South Carolina hired "resource mothers" to work with teen mothers-to-be to educate them on prenatal care and how to care for their young newborns. There are many other such programs which Alabama could, and should, emulate.

But a key factor in any effective program to reduce infant mortality is the number of mothers-to-be who are eligible for Medicaid help with their prenatal and post-natal medical bills.

Since 1984, the Southern states of Mississippi, Texas, South Carolina, Georgia, North Carolina, Florida, Tennessee, and Virginia have expanded their Medicaid coverage to provide more care to more pregnant women who otherwise could not afford that care.

Until this year, Alabama was absent from that list provided by the Southern Governors' Association. This year, the state put a measly $1 million into expanding Medicare coverage for mothers and their children. And, as difficult as it is to believe, the Alabama Legislature allocated that $1 million over the objection of the Hunt administration.

The Legislature was poised to allocate $5 million, but the Hunt administration said it was not prepared to spend that much. Since that money would have been matched 3-to-1 by federal funds, the state lost many millions more in federal money which could have been spent to save the lives of hundreds of Alabama babies.

It is no accident that Alabama has not only the highest infant death rate, but also the most restrictive Medicaid eligibility standards for mothers and their children.

A family of three cannot earn more than $1,416 per year — that's right, per year — and still qualify for Medicaid coverage. That is only 16 percent of the federal poverty standard.

Gov. Guy Hunt has promised that after a year of study, he will lead an initiative to reduce infant death rates. We hope he means what he says. But if not, the Alabama Legislature has shown it is willing to do something meaningful if the governor will just get out of the way.

But he needs to do more than that. Most states which have significantly reduced infant death rates have done it with leadership from their governors' offices. Gov. Hunt needs to provide that same leadership in Alabama. — **The Montgomery Advertiser, Sept. 20, 1987.**

About the writers

Frank Bass, 24, covers health, state agencies, the environment and national politics for The Alabama Journal. The Houston native is a graduate of Texas Tech University. He worked at The Lubbock Avalanche-Journal and the Columbus (Miss.) Commercial Dispatch before coming to Montgomery in October 1985.

Emily Bentley, an Oneonta native, covers the Legislature and state politics for The Journal. Bentley, 23, is an Auburn University graduate who has worked for The Journal since 1985. She initially was the paper's correspondent in Auburn while still in school, then joined the staff full-time in Montgomery in March 1986.

Susan Eggering, 28, covers education for The Journal. She came to Montgomery in June and previously worked for The Anniston Star and The Washington Missourian in Washington, Mo. A native of Arlington, Mass., she is a graduate of the University of Missouri at Columbia.

Peggy Roberts, 29, is a former business reporter for The Journal. She currently is assignments editor at WAKA-TV in Montgomery. A native of Norwich, Conn., she is a graduate of the University of Connecticut. Before coming to Montgomery in 1986, she worked for publications including the Houston Business Journal and The Norwich Bulletin.

Not Just Numbers

For every 1,000 babies born in Alabama, more than 13 of them die before their first birthday. That's the worst record of any of the 50 states.

But that's only the beginning of a shameful story. There are counties just a short drive from Montgomery where babies die at twice that rate. Take Bullock County, less than an hour's drive south on Interstate 65. More than 26 babies out of every 1,000 live births die there before completing their first year of life. The same is true of Butler County, less than a half-hour drive southeast of the Montgomery city limits.

But the worst example is Wilcox County, where the infant death rate is three times higher than the Alabama rate — which, don't forget, is the worst of the states. In those counties, and in many other poor, rural counties in Alabama, newborn infants have a much poorer chance of survival than in many so-called "backward" Third World countries.

Those statistics are a blight on Alabama, but they are only statistics, numbers that we have written about time and again. And we will continue to write about such numbers until the tragedy they represent diminishes dramatically.

But the real horror behind those numbers has been uncovered for Alabamians this week by an excellent series of articles in The Alabama Journal. It is hard to imagine anyone who could fail to be moved by the descriptions given by mothers, doctors and social workers who have had to live with these infant deaths.

A Camden mother who lost a child told it much better than we could:

"He had so many doctors, I couldn't name them. But they still didn't tell me what was wrong. They said, 'We're going to run some tests.'

"They began to show me his heart, what he looked like inside — his right side that never did develop, that was twisted back in him.

"I never knew what was wrong. I asked the doctor and he said it was his heart — and several other things.

"I cried and cried.

"The doctor wouldn't tell me no more 'cause I was hollering so.

"But he was so good. They don't holler much, babies born with heart problems, the doctor said."

None of these young babies holler much, nor do their parents, usually young — too young — and usually poor and uneducated, too. They are not sophisticated in dealing with the news media or politicians, so there is seldom anyone "hollering" for them on the front pages of our newspapers or on our TV screens or in the halls of the Legislature.

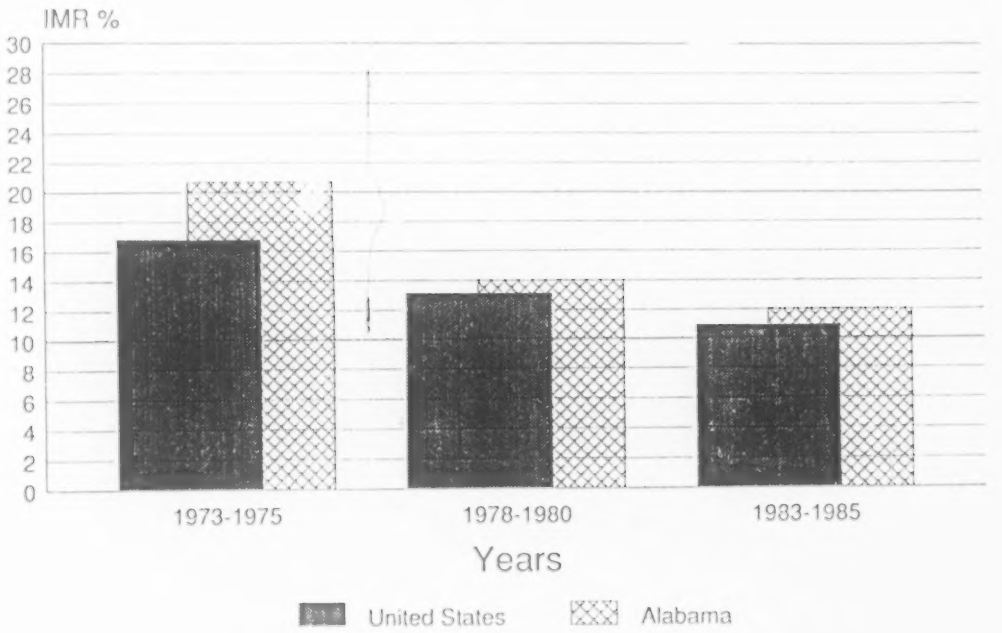
There are many factors that contribute to the tragedy of Alabama's infant mortality rate. It is tied up in poverty, ignorance, race, an uncaring government, minimal health care, nutrition, and on and on.

But never let any politician tell you there is nothing he can do about it. There are things that can be done. Other states are doing them, and the record in those states shows that many of these programs cost relatively little when compared with other government services.

But for these things to be done in Alabama, it first takes someone willing to holler, and cry, and cajole, on behalf of these youngsters and their parents. We must never forget that these grim statistics represent the needless deaths of hundreds of babies and the agonizing of parents who loved them.

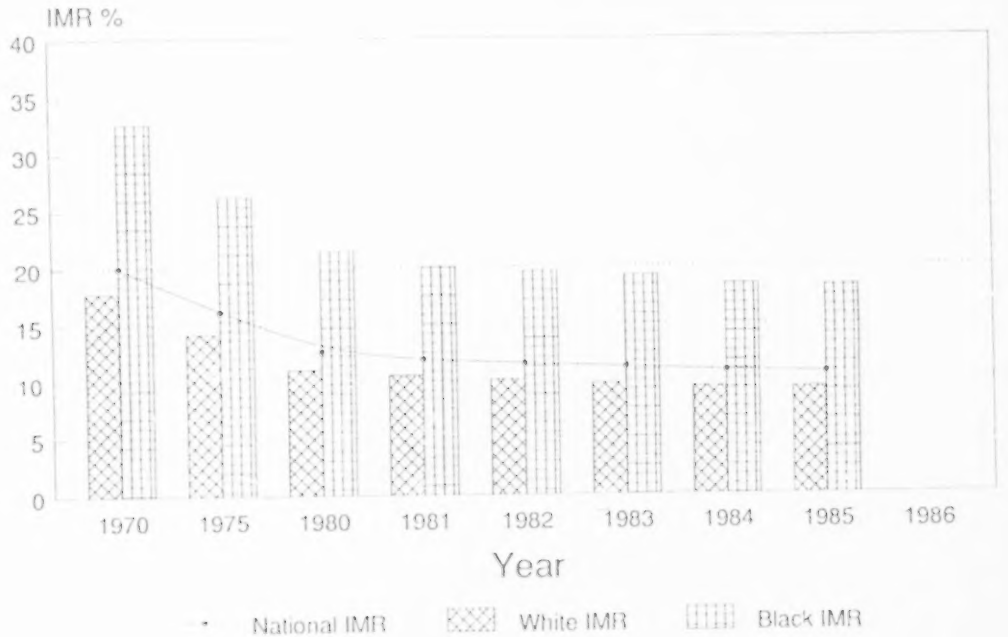
Alabamians can do something about infants who die needlessly. For the sake of our future, our humanity, even our souls, it's time we started. — **The Montgomery Advertiser, September 18, 1987.**

Infant Mortality for all Races in the United States and Alabama for selected years



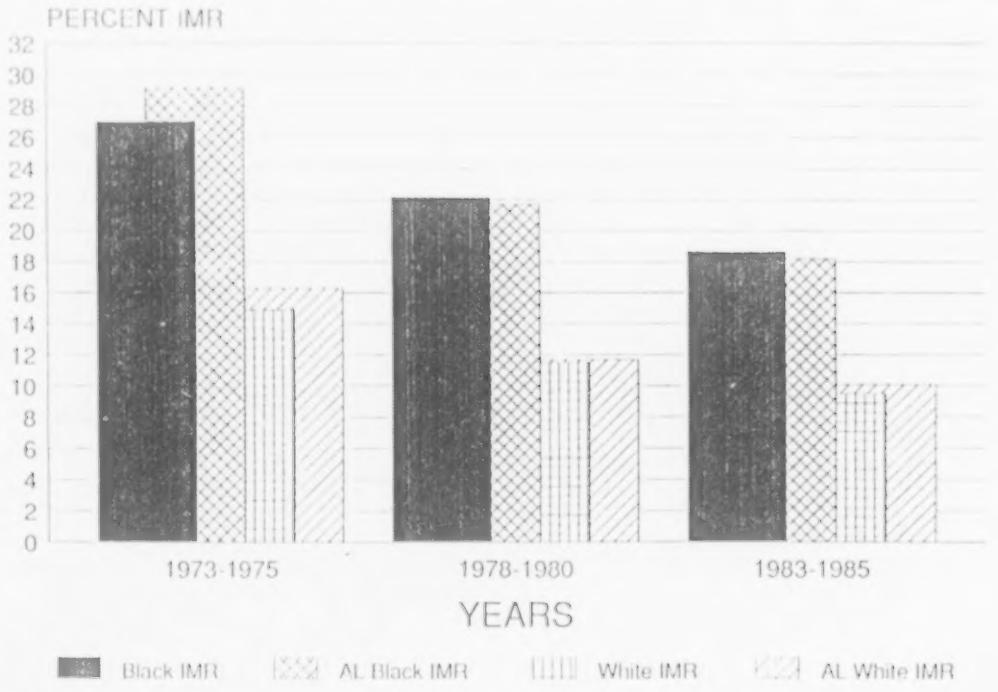
National Center For Health Statistics

Infant Mortality Rate (IMR)
for the U.S.
1970 - 1986



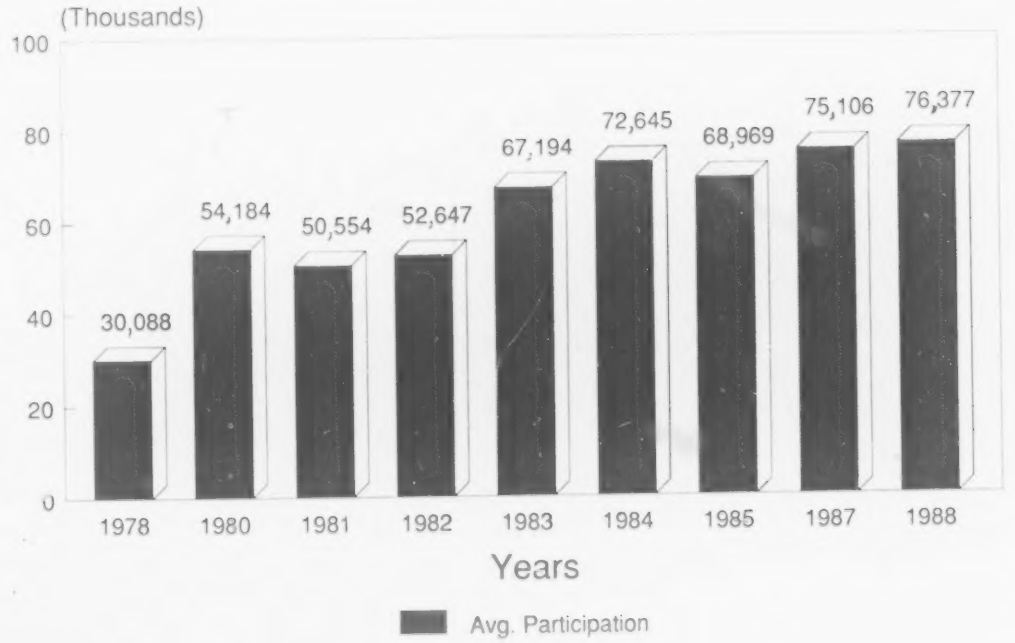
National Center For Health Statistics

Black/White Infant Mortality Rates
for the Nation and Alabama



National Center For Health Statistics

Average Monthly Participation in the Alabama WIC Program



Source: Alabama Dept. of Public Health
1978: 94 served 175% Poverty Guidelines
1985: 87 served 150% Poverty Guidelines

Medicaid Participation:
Women and Children, 1978 - 1987

Year	Women	Children (0 - 6 years old)
1978	202,887	40,230
1979	218,085	47,897
1980	218,453	53,415
1981	223,204	39,714
1982	216,030	40,191
1983	209,623	40,369
1984	212,382	50,429
1985	213,051	59,580
1986	212,780	60,743
1987	206,075	56,491

Source: Alabama Medicaid Agency
(data provided via phone)

Prepared Statement of Joseph Phillips, M.D., Director, Regional Newborn Intensive Care Unit, University of Alabama at Birmingham Division of Perinatal Medicine, 1987–1988 Financial Synopsis

Patient population served by the Division of Perinatal Medicine for the period of 10/1/87 through 9/30/88, continues to reflect an increase in the admittance of patients who have no insurance or who are Medicaid recipients. Patients with no insurance coverage made up 22.31% of our population. Medicaid recipients numbered 46.14% of our patient population. A total of 31.55% entered our care with private insurance coverage.

Total charges and payments pertinent to these three categories are reflected in the attached graphs, A and B, respectively.

It is essential in evaluating this data to be aware of the pay/charge ratios of each source. The percentage of charges actually collected are as follows:

Private Insurance Coverage	55.69%
Medicaid	24.22%
No Insurance (Personal)	6.70%
(Graph C)	

Distribution of total write-offs for the past year are reflected in Graph D.

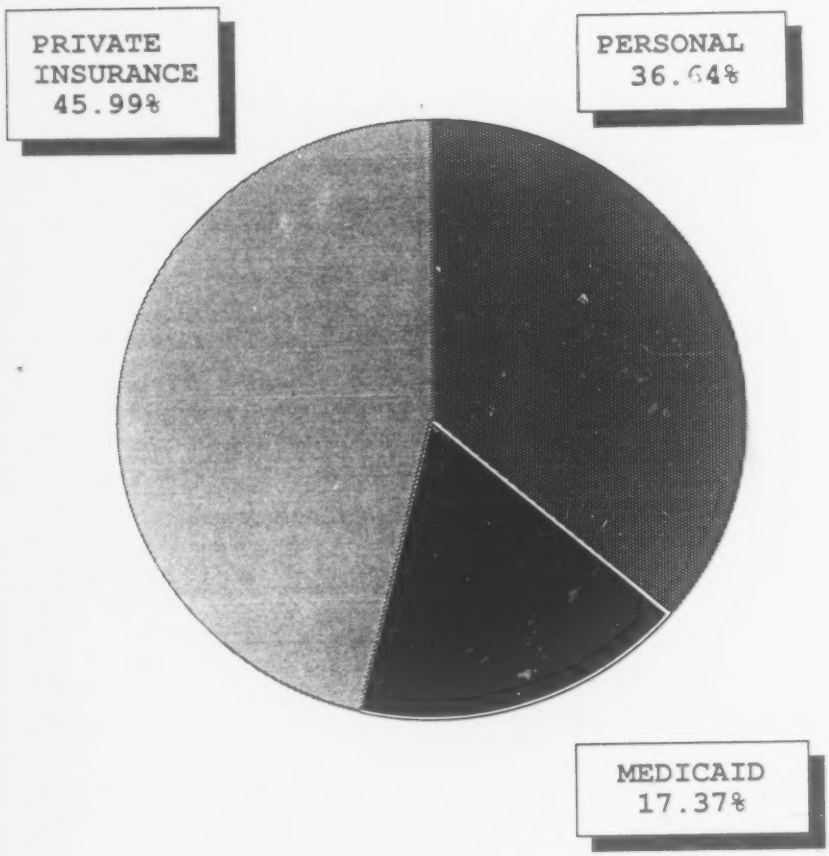
The percentage of write-offs from private insurance coverage, 27.19% of the total, is as expected with our fairly high number of patients covered under PMD, Champus, and other such insurance with whom we have agreements to write off any noncovered balance.

There are several factors influencing the Medicaid write-offs. First, for the majority of the procedures performed, Medicaid reimburses somewher between 16% and 50% of the normal and usual charges. Second, Medicaid only provides coverage for 12 days per year. We are legally allowed to bill the family for days which exceed this limitation; however, it goes without saying, that these families are seldom in a position to pay for these services. A third factor which hinders reimbursement from Medicaid is the fact that only two specific procedures are allowed under the mother's Medicaid number. For all other procedures, Medicaid requires us to have the baby's Medicaid number. For this, we must depend on the mother to obtain the number and contact us with the information. This a rather lengthy process taking up to eight weeks which not only substantially decreases our chances of collection from Medicaid, but also causes what would seem to be an unnecessary chore for the families of seriously ill infants. It is our understanding that there are other states that are more flexible regarding this issue.

Our final segment of write-offs, those babies with no insurance coverage whatsoever, continues to grow. The reasons for failure to pay are endless--unemployment, more pressing creditors (i.e. housing, utilities, food), and more. We understand that families of seriously ill infants who may be hospitalized for several weeks or months face medical bills of literally thousands and thousands of dollars. We try to work with them in any way possible to make payments for our services in order to minimize their hardship, but as reflected in Graph C, our recovery of these charges is only 6.7%.

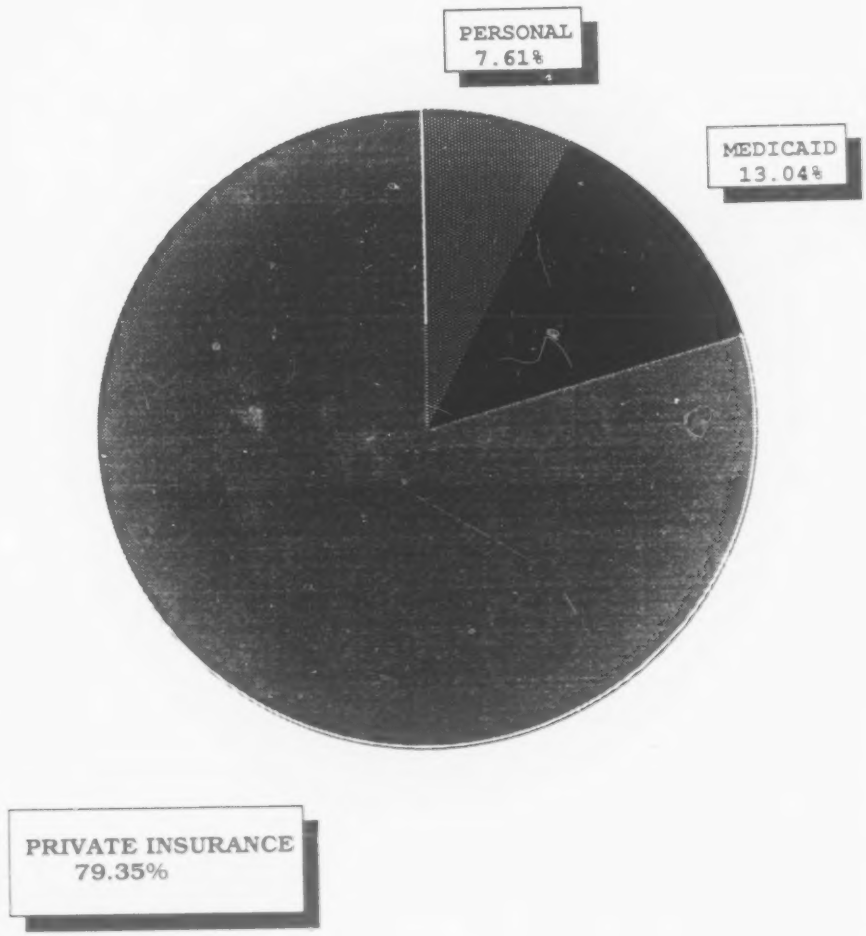
It is hoped that this very brief overview has provided some insight into the dilemma faced by the families of our particular patient population as well as the care providers for this very precious resource.

CHARGES BY SOURCE



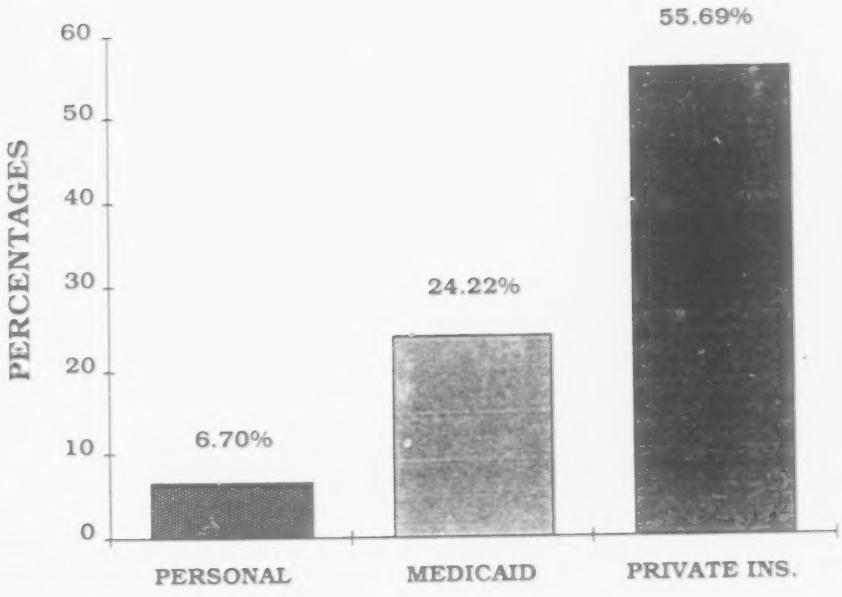
GRAPH A

PAYMENTS BY SOURCE



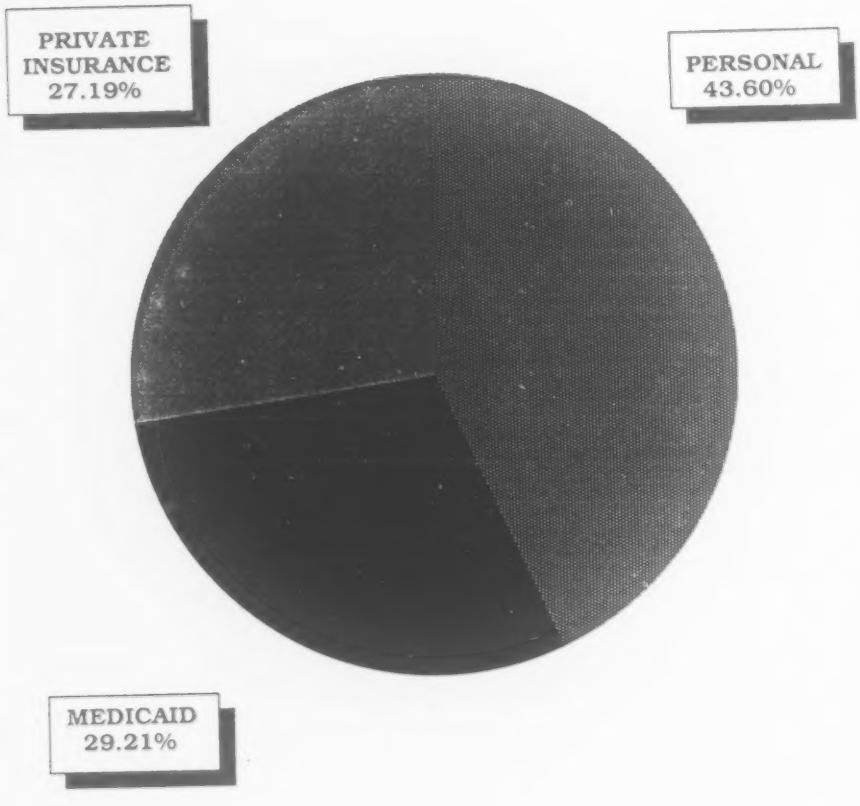
GRAPH 8

PAY/CHARGE RATIOS



GRAPH C

WRITE-OFFS BY SOURCE



GRAPH D

PREPARED STATEMENT OF SENATOR LAWTON CHILES, A U.S. SENATOR FROM FLORIDA AND CHAIRMAN, NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

Mr. Chairman, I would like to thank you for allowing me to share some of my thoughts and recommendations for the fight against infant mortality. First, I want to commend you and the other members of your Committee for holding the special session in Alabama on the critical topic of infant mortality prevention.

For the past year, as Chairman of the National Commission to Prevent Infant Mortality, I went around the country asking a lot of questions. Some 40,000 Americans under the age of one died last year. And yet, except for families and friends, most of the nation barely noticed.

In a series of hearings, from Los Angles to New York, our Commission focused on solutions to reduce infant mortality We heard from parents, physicians, media experts,church leaders, policy makers and international experts in the field of maternal and child health. And, together, we worked to find out why children "die before their time" and what can be done to stop it.

We learned a great deal. And I will share with you what we learned.

What makes infant mortality a particularly perplexing issue is that the United States has already spent a lot of money on the problem. Technological research has greatly advanced neonatology in this country, and social programs created over the past 50 years abound for poor women and children.

How, then, does a wealthy and technologically sophisticated nation reconcile its poor infant mortality status with the substantial investments already made in federal and state efforts to address the problem?

Why is there still a problem ?

Past successes in reducing infant mortality have been due, in large part, to medical technology's ability to save smaller and smaller babies. But that technology is now reaching the limit of its ability to save these babies, contributing to the recent leveling off of the nation's infant mortality rate.

Other causes involve the financial barriers and bureaucratic tangles that inhibit poor women - often single and uneducated - from seeking the necessary prenatal care. These mothers often deliver babies who are victims of poor maternal nutrition; maternal consumption of alcohol, tobacco, and other harmful drugs; and inadequate spacing between pregnancies. These are the infants most likely to be born underweight and therefore most at risk.

The Medicaid program is illustrative of a well - intentioned federal - state assistance effort that often unwittingly thwarts it own objectives. The largest public insurance program for the poor, Medicaid covers only about 38 percent of Americans with incomes below the 1988 federal poverty level of $9,690 for a family of three. The low coverage is due in part to Medicaid's often stringent eligibility requirements. While Medicaid is funded by the federal and state governments, it is administered individually by the states, so eligibility requirements and benefits vary tremendously from one state to the next. Thus, causing confusion on the part of health care providers and low income families regarding whether they are eligible for services and what services are covered.

The near poverty-level working poor do not fare much better at getting private insurance coverage. In 1985, about 7.3 million women of childbearing age who were employed or married to workers were not covered by health insurance. Another 5 million women of childbearing age had private insurance that did not cover maternity care.

For many American women, access to proper prenatal care is severely limited by the fact that federal and state social service programs often operate in isolation, without a network linking the financial, food, medical and other benefits available to the needy client. Programs are frequently administered by different agencies and at different locations.

Other difficulties in obtaining care include inconvenient clinic hours and locations, lack of transportation and child care, and the scattering of services over a wide geographic area. These difficulties are compounded by a shortage of health care providers unwilling to care uninsured or publicly insured women and infants, providers unable to speak the languages of those they serve, low reimbursement rates, and provider's malpractice and liability concerns.

What does the problem cost ?

The primary cost of infant mortality is human,and therefore immeasurable. The cost of "graduating" a sick infant from intensive care ranges from $20,000 to $100,000. Next comes the expense for long term care for children who survive but need assistance in caring for themselves due to physical or mental disabilities.

According to the Southern Governors' Association, the average overall cost for lifetime health and custodial care for a handicapped child can reach $400,000.

Expensive as direct health care costs are, however, they are not the only economic costs of infant mortality. Indirect costs - such as wages that might otherwise have been earned eventually by the infants or parents - are also substantial. A recent study by the Actuarial Research Corporation placed the total current value of the future earning of 1985 infant mortality victims at $10.2 billion to $18.9 billion.

What are the Commission's proposed solutions ?

Adequate prenatal and pediatric care are the answers; every report on the subject since 1900 has said as much.

The Commission identified two main courses of action to help the United States break out of the stagnation that has characterized the infant mortality rate since 1975.

First, universal access to early prenatal and pediatric care should be provided for all infants and mothers, without financial, geographic, social, educational or administrative barriers. Employers must make available health insurance coverage that includes maternity and well-baby care. Government must assume responsibility for those who lack private insurance or who are unable to pay.

Second, we must initiate immediately a sustained, broadbased effort to make the health and well-being of mothers and infants a national priority and give them the public attention and resources they deserve. We recommend establishing a national council on children's health and well being which would centralize leadership on children's health issues. The council could assist the President in sponsoring a 1990 White House Council on Children's Health, an instrumental step in returning children's health and well-being to the national agenda.

The primary responsibility toward guaranteeing pregnant women and infants with financial access to maternity and infant care rests with the private sector and employees who help provide the vast majority of health care in this country. In addition, we call for uniting the public and private sectors in a national campaign to

focus attention on infant mortality prevention. Both the private and public sectors must be joined together in heightening public awareness about the need to improve access to health care for all pregnant women and children.

Quality services and comprehensive, coordinated care are critical elements of the service delivery system for pregnant women and children. The federal government, state governments and the private sector must combine their efforts to ensure the availability of obstetric providers and quality care.

It is not inevitable that 40,000 American infants die each year;many of those deaths are preventable. As a nation, we must work together to provide political leadership and national commitment for the health and well - being of our children.